Prevention of Child Abuse and Neglect (POCAN) Final Evaluation Report

Department of Health and Family Services
Office of Strategic Finance
Evaluation Section

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Executive Summary

Child abuse and neglect are preventable tragedies, yet thousands of Wisconsin children become the victims of neglect and abuse each year. In 2001, the most recent year for which data are available, 9,795 reports of suspected child abuse and neglect were substantiated. Of those, 1,327 reports involved children under two years of age.

Some children are maltreated so severely that they die. Infants are especially vulnerable; of the 17 child fatalities in 2001, where there was substantiated abuse or neglect, nine of the victims were under one year of age.

The good news is that substantiated reports of child abuse and neglect dropped 40 percent from 1997 to 2001. Part of the reason has been a recognition that early intervention on behalf of children is an effective means of prevention when it is combined with extensive services for families in distress.

One such approach is Wisconsin's Prevention of Child Abuse and Neglect Program, now being piloted in nine counties and one tribe. The Governor and the Legislature established the program in 1999. Administered by local human service or public health agencies, the program is a comprehensive public health home visitation effort based on the "Healthy Families of America" model, which has been demonstrated by solid research data to be effective at preventing child abuse and neglect.

The goal of this prevention effort is to reduce child abuse and neglect and out-of-home placements by improving child health, parenting skills and family functioning of participants. Participants of the home visitation program must be Medicaid eligible. In addition, participants must be first-time parents with infants or toddlers who have been determined to have risk factors for child abuse and/or neglect. Enrollment is on a voluntary basis. Program participation and home visitation are intended to continue until the child is three years of age.

Under the program's auspices, paraprofessionals provide home visits under the supervision of nurses, social workers or child development specialists. The intensity of home visiting services is based on the needs presented by each family. Generally, home visits occur at least weekly during the early stages of participation, and decrease in frequency over time.

Counties and tribes competed to be selected as pilots. Thirty-one counties and one tribe submitted proposals. Ten Projects were chosen for funding. The 10 Projects are located throughout the state in nine counties (Brown, Door, Fond du Lac, Manitowoc, Marathon, Portage, Vernon, Waukesha and Waupaca) and one tribe (Lac Courte Oreilles). From program inception in 1999 through Calendar Year 2003, the Department of Health and Family Services has allocated a total of $5,476,348 in state funds to the 10 Projects.

The legislation required the Department to evaluate the home visitation program. An interim evaluation report was issued in May 2001. It presented descriptive data on the study population of clients enrolled during the period July 1, 1999 through June 30, 2000 and on services provided during fiscal year 2000. This final evaluation report, which is based on the same study population, includes an analysis of the Projects' activities, as well as data on the client outcomes mandated by the enabling legislation.

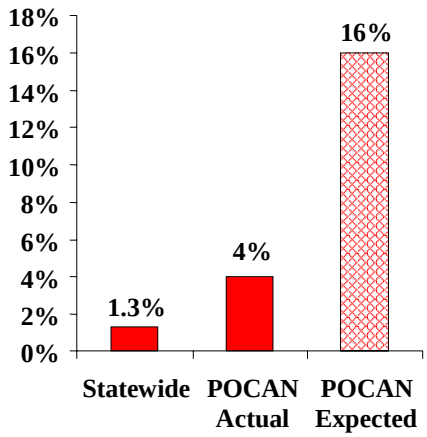
The study population includes 236 families. Caseloads for individual Projects range from 9 to 53. The average age of infants upon enrollment in the program was 2.6 months. The average age of mothers at the time of enrollment in the program was 20, and the average age of fathers/parenting partners was 23. Ninety-eight percent of the mothers were single, 51 percent had fewer than 12 years of education and 59 percent were unemployed at the time of enrollment.

Outcomes among the study population were positive. Based on national research for this type of service model, this innovative program is successful in preventing child abuse and neglect, facilitating the delivery of appropriate and necessary preventive and acute medical care, and improving parenting skills.

Several outcome measures are specifically required by the legislation. It was found that among the program study population, these outcomes were positive relative to comparative data that were analyzed. The findings regarding these legislatively mandated evaluation outcomes were:

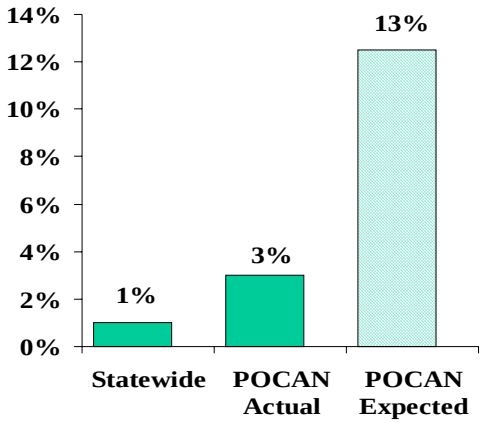
- There were 11 substantiated abuse/neglect reports on 10 children (4 percent of the study population) while participating in the program. Based on the target population served, the substantiated abuse/neglect rate is estimated to be 16 percent without the program's services.

Substantiated Child Abuse/Neglect Cases



- 8 children (3 percent of the study population) were in a formal out-of-home placement at some point during the prevention program. The expected out-of-home placement rate might have been as high as 13 percent without these services.

Out-of Home Placements

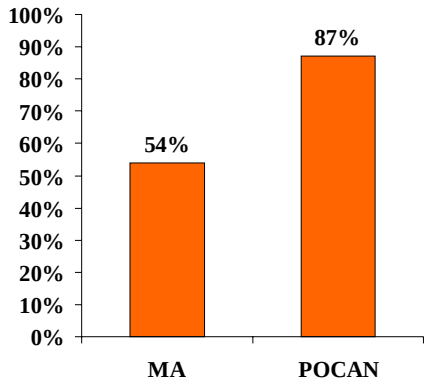


- 16 children (7 percent of the study population) used an emergency room during the program to receive treatment for injuries. The rate of emergency room use for both illnesses and injuries was .36 visits per year among children in the program. In comparison, the rate of emergency room use among Medicaid children age 0 to 5 was .76 visits per year.

- 83 percent of children were reported to have received all scheduled HealthCheck exams. This exceeded the federal standard of 80 percent.

- 87 percent of children were reported to be up to date on their immunizations. In comparison, 54 percent of Medicaid eligible 2-year-olds received all scheduled immunizations during 2001.

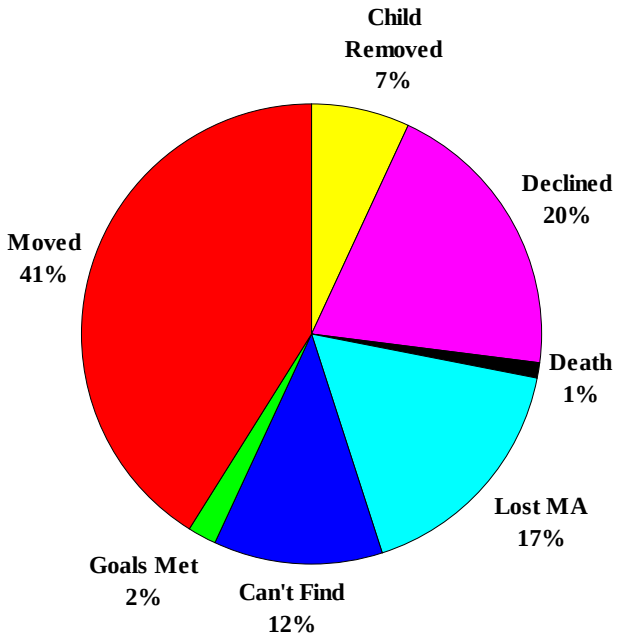
Immunizations



The statutes also directed that the Department report on other outcomes relating to program retention, enhanced child development, strengthened family functioning, positive parenting practices, and any other items that were determined to be appropriate for evaluation. The Department was given flexibility in how to evaluate these outcomes.

Program retention is typically problematic with home visiting child abuse prevention programs. During the first three years of operation, the closure rate for the overall study population was 62 percent. Closure rates for individual projects ranged from 25 percent in Portage County to 80 percent in Fond du Lac County. The most common reason for closure was that the family moved out of the county (41 percent of all closures). County residency is a program requirement. The closure rate without the cases that moved was 36 percent.

Reasons for Withdrawal from POCAN Program



Most (87 percent) of the study population was screened to analyze child development and to assess whether children were within developmental norms. There were 26 children in the program *(*13 percent of the screened cases*)* who were identified as having developmental delays. Most (25 of 26) of these children were referred to the Birth to 3 Program and 20 children (8 percent of the study population) received Birth to 3 services.

The evaluation found statistically significant improvements in family functioning and positive parenting practices among families in the program. Improvements in family functioning and positive parenting practices were assessed via client scores on the Home Observation for Measurement of Environment (HOME) instrument. Projects were required to administer the HOME to clients three times; i.e., when the child was 6, 12 and 18 months of age. The greatest improvements were made between 6 and 12 months. Statistically significant improvements in total HOME scores were found between the assessments done at 6 and 12 months (increasing by 2 points or 6 percent) and also between the assessments done at 6 and 18 months (increasing by 2.5 points or 7 percent). Of the individual dimensions of the HOME assessment, positive parenting practices relating to the availability of learning materials for the child showed the greatest improvements, improving by 1.2 points or 17 percent between 6 and 18 months.

Some clients improved their employment status or their educational status while they were receiving prevention services. Employment status at the close of follow-up was compared with that at intake and it was found that 28 percent of the mothers had increased their level of employment. There were 34 cases where the mother had improved her educational status by initiating or completing an educational program. Among those cases that made educational progress, 19 attained their high school diploma/GED, six completed high school and went on to college, seven who already had their high school diploma at intake initiated a college educational program, and two who had some college at intake completed their degree.

The prevention projects provided case management services to families and referred many clients for needed services. The evaluation found that in many cases, clients received the services they were referred to, and that the vast majority (98 percent) of children had a primary care physician at the end of follow-up.

This study makes several recommendations:

- Target the program better to enroll families in close timing to the birth of the child.
- Assess family functioning and positive parenting practices upon intake and throughout POCAN participation.
- Thoroughly assess risks using the Prenatal Care Coordination (PNCC) Questionnaire or the Family Questionnaire to better quantify risk level and systematically identify program and treatment needs.
- Do more intensive assessment and case management to identify treatment and services needs and additional follow-up to facilitate implementation of referrals.
- Explore how federal MA funds can be maximized to support the prevention program.
- Promote service continuity among families that close due to moving.
- Analyze options for program expansion to eventually make prevention services available throughout the state.

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POCAN Program Description

The Governor and the Legislature established the Prevention of Child Abuse and Neglect (POCAN) program through 1997 Wisconsin Act 293 (S.S. 46.515). This legislation was introduced as a result of study by the Legislative Council Special Committee on Child Abuse and Neglect. The goal of POCAN is to reduce child abuse and neglect and out-of-home placements by improving child health and family functioning for participants through a comprehensive program of in-home visitation. POCAN provides intensive case management services to improve parenting skills and to facilitate the safety and well being of children at risk of child abuse/neglect. The POCAN program is based on the Healthy Families of America accreditation guiding principles and quality assurance standards. The Healthy Families of America early childhood in-home visiting program model has been demonstrated to improve parenting skills and prevent child abuse and neglect in many states.[1]

POCAN provides services to two distinct populations. The primary POCAN program provides home visitation services to families with very young children. Paraprofessionals provide home visits under the supervision of nurses, social workers or child development specialists. The intensity of home visiting services is based on the needs presented by each family. Generally, home visits are at least weekly during the early stages of participation and decrease in frequency over time. POCAN enrollment is intended to be in close proximity to the child's birth, and program participation and home visitation are intended to continue until the child is three years of age. To be eligible for program participation, home visitation clients must be first-time parents who are Medicaid (MA) eligible and have been determined to have risk factors for child abuse and/or neglect. Per statute, POCAN participation is voluntary.

The second client group that is served using POCAN funds receives wraparound services. These families have either been the subject of a child abuse/neglect report or have asked for assistance to prevent abuse/neglect. These families must be willing to cooperate with an informal plan of services and have no court involvement. Wraparound services are intended to keep families out of court. Wraparound cases are distinct from the POCAN home visitation program caseload, and eligibility criteria are also different. Medicaid eligibility is not required to receive wraparound services, families may have multiple children and the children may be older. The statutes did not require an evaluation of the wraparound program and it is not specifically evaluated in this report. This report does present data on the funding and caseloads of the wraparound program.

The legislation enacting POCAN did not prescribe a specific model of home visitation services for the program. However, there are basic common elements that all POCAN Projects use in the operation of their program. For example, there is always an initial screening and assessment to identify risks and plan service needs, and the nature and intensity of services are individualized based on these needs. There is also a consistent focus on child-parent interactions and child development, health and safety. The POCAN home visitation programs all provide significant intensive family supportive and educational services during frequent, often weekly, home visits.

[1] The David and Louise Packard Foundation, The Future of Children: Home Visiting Recent Program Evaluations, Volume 9, Number 1 –Spring/Summer 1999.

The Department of Health and Family Services (DHFS) administers POCAN via cooperative agreements between the Division of Children and Family Services (DCFS) and the Division of Public Health (DPH). The Division of Public Health provides 12 Critical Elements as guiding principles for the POCAN Projects to use to operate their home visitation programs. The Critical Elements specify best practices that have been demonstrated to result in positive family outcomes. These 12 Critical Elements are based on the National Healthy Families model for home visitation programs. All projects are expected to implement these elements to promote program consistency and quality services. The Projects have flexibility in how they implement the 12 Critical Elements to best meet local needs. The 12 Critical Elements are:

1. Initiate services during the prenatal period or at birth.
2. Use a standardized assessment to identify families in need of services.
3. Offer services voluntarily and develop a regular visitation schedule with the family.
4. Offer services based upon needs, changing the intensity of services over time.
5. Offer culturally competent services with staff and materials that reflect the populations being served.
6. Focus on the parent as well as parent-child interaction and child development.
7. Link all families to a health care provider and other services depending on need.
8. Limit staff caseloads so home visitors can have adequate time with each family.
9. Select appropriately prepared staff who are skilled and willing to work with diverse communities.
10. Select staff whose education and/or experience enable them to handle the experiences of working with overburdened families.
11. Provide staff with intensive training specific to family assessment and home visitation.
12. Ensure that staff receive ongoing supervision so they can develop realistic and effective plans to help families meet their objectives, aid those who may not be making progress, and discuss their concerns to solve problems and avoid stress-related burnout.

Division of Public Health and University of Wisconsin Extension staff visited the POCAN Project sites to evaluate the degree to which the POCAN Projects implemented the 12 Critical Elements. A summary of their conclusions are included in Appendix A. A copy of their full report may be obtained by contacting the DHFS Division of Public Health.

DHFS implemented POCAN through grants to County Human/Social Services Departments, Public Health Departments and the Lac Courte Oreilles Tribe. Each POCAN Project has a somewhat varying organizational and service delivery structure that relates optimally to local needs and circumstances. For example, in some cases the POCAN Project is operated by the County Human or Social Services Department, and in some cases, it is operated by an independent County Public Health Department. Many Projects use county staff to provide home visitation services, but some contract with local established, home visitation providers for these services.

Thirty-one counties and one tribe submitted POCAN Project proposals for competitive ranking. After Departmental review, 10 Projects were chosen for funding. The 10 Projects are located throughout the state. Three urban counties *(* Brown, Marathon and Waukesha), 6 rural counties

(Door, Fond du Lac, Manitowoc, Portage, Vernon, and Waupaca) and one tribe (Lac Courte Oreilles) were selected as POCAN Projects. The official start date for the POCAN Projects was January 1, 1999. Current client capacity ranges from 6 families in the Lac Courte Oreilles Tribe to 90 families in Brown County[2].

POCAN Funding

The legislation that authorized POCAN provided a funding level of $995,700 GPR annually for the program and $160,000 GPR annually for training and technical assistance. Program funds are allocated to participating counties by a formula that is specified in statute. Each POCAN project received a base award of $10,000. Additional funds are allocated based on each county's 1996 Medicaid birth rate. Total allocations range from $25,603 annually for the Lac Courte Oreilles Tribe to $265,130 annually for Brown County. Appendix C presents detailed information on the POCAN funding that was allocated to individual POCAN projects from program inception in 1999 through Calendar Year (CY) 2003.

POCAN program allocations fund three separate programs: home visitation, flexible funding services and wraparound services. Home visitation services, in which paraprofessional home visitors provide case management and child abuse/neglect prevention services to families at risk of child abuse, are the core services provided by the POCAN program. In CY 2002, $930,400 GPR was allocated for the home visitation program and used to serve 377 families.

The POCAN program also includes an allocation for flexible fund services that can be used for appropriate expenses for home visitation program families. Flexible funds are used to provide home visitation families with needed services that they are unable to meet, and for which there is no other source available funding. The services provided with flexible funds are generally items needed for young children, such as infant car seats, but may also include crisis-related items such as a security deposit for an apartment or payment of delinquent utility bills. Local POCAN programs determine the amount and types of services that are provided using these flexible funds based on individual family needs and county resources. Flexible fund expenses may not exceed $1,000 per family each year. Local programs are required to provide a 50% cash match for all flexible fund services expenditures and must determine the amount of their match as part of contract negotiations each year. In CY 2002, $42,100 GPR was allocated for flexible fund services and matched with the same amount of county funds. Flexible funds were used to serve 233 POCAN home visitation program families in CY 2002.

Finally, the POCAN program includes an allocation for wraparound client services. Wraparound services are provided to families who are not POCAN home visitation clients but who are at risk of becoming part of the child protective services caseload. Services provided include crisis-driven services such as rent, services related to older children such as school supplies, and services provided by a social worker. As with flexible fund services, local programs are required to provide a 50% cash match for all wraparound service expenditures but may not exceed $500

[2] "Current capacity" refers to the number of different families that are on the active home visitation caseload at any given point in time.

per family annually. In CY 2002, $23,200 GPR was allocated for wraparound services and matched with the same amount of county funds. POCAN wraparound funds were used to serve 196 families in CY 2002.

Each local project receives a single allocation for all three programs. As part of the annual contract negotiations, local projects are required to determine the number of clients they will serve in the home visitation, flexible fund and wraparound services programs as well as the amount of the match they will contribute to both the flexible fund services program and the wraparound services program. The Department approves this budget when it approves the final contracts with local projects.

Funding for POCAN was initially appropriated in state Fiscal Year (FY) 1999. Because county contracts are on a calendar year basis, DHFS was able to provide half a year of funding ($487,820 GPR) to the 10 POCAN projects for initial start-up/capacity building and one-time operation costs[3], as permitted by statute. As a result, in CY 1999, local projects received 18 months worth of funding.

The annual allocations to each project have remained the same since CY 2000. Local projects received $1,493,548 GPR in CY 1999, and $995,700 annually in CY 2000, CY 2001, CY 2002, and CY 2003. Total state funding available to the POCAN projects between CY 1999 and CY 2003 was $5,476,348 GPR.

Federal Funding

Some, but not all of the services POCAN provides qualify as Targeted Case Management services under the federal Medical Assistance (MA) program and are eligible for federal MA reimbursement. Local projects are expected to bill MA for Targeted Case Management services. Over the three-year period of the evaluation, FY 2000 to FY 2002, $111,944 FED in Targeted Case Management funds was captured for services provided to the POCAN study population.

Original legislation for the POCAN program provided $160,000 GPR for training and technical assistance. State funding reductions over the last five years have eliminated this funding. In the place of state funding, the Department has substituted federal funding. The Department currently allocates $160,000 FED annually from Child Abuse and Prevention Treatment Act (CAPTA) funds for training and technical assistance to the home visitation programs. DHFS contracts with the University of Wisconsin-Extension for training and technical assistance services for the POCAN projects.

[3] Start-up and capacity building costs include costs related to delivery systems, workforce, policies, support systems (such as information systems and technical assistance), and other infrastructure needed to initiate and maintain service delivery and policy-making activities.

Purpose of This Report

1997 Wisconsin Act 293 funded the POCAN program and required an evaluation of the program. The enabling legislation mandated that several specific outcomes be reported. These included:

- The number of substantiated reports of child abuse and neglect
- The number of emergency room visits for injuries to children
- The number of out-of-home placements of children
- Immunization rates of children
- The number of Health Check services provided to children
- The number of families who remained in the home visitation program for the time recommended in their case plan
- Strengthened family functioning
- Enhanced child development
- Positive parenting practices

This report was produced to meet the statutory mandate for an evaluation that was contained in the enabling legislation. The results of this report will be used to determine the effectiveness of the POCAN Projects in reducing child abuse and neglect and improving child health and family functioning. The results will also be used to inform decisions regarding continued funding of the current POCAN Projects and possible POCAN program expansion.

Methodology

All clients enrolled by the POCAN Projects during Fiscal year (FY) 2000 were included in the original study cohort. The study cohort includes a total of 236 POCAN cases from nine county projects (Brown, Door, Fond du Lac, Manitowoc, Marathon, Portage, Vernon, Waukesha and Waupaca). The Lac Courte Oreilles Tribe was also selected as a POCAN Project; however, this Project experienced early implementation challenges. Only two cases were enrolled during FY 2000 when the study cohort was identified, and staff turnover during the first eighteen months of the POCAN grant period delayed full implementation of the Lac Courte Oreilles Project. As a result, the Lac Courte Oreilles Project was excluded from the study cohort since these cases did not receive the intended case management and other services that are integral to effective implementation of the POCAN program.

All projects collected client specific descriptive data on the child, the mother and the father/parenting partner upon POCAN enrollment. This intake data included client demographic data on all family members and other descriptive data on parents. One eligibility criterion for POCAN enrollment is the potential risk for child abuse/neglect. Each family was assessed using validated risk instruments that are used in other DHFS programs. This risk assessment data was also collected and analyzed for this study.

Each client from the cohort was followed throughout his or her program participation for a maximum of three years, through June 30, 2002. This report reflects data on client outcomes through June 30, 2002 if the case was still active on this date or through POCAN closure if the case was closed prior to June 30, 2002. The Projects submitted several types of outcome data to allow the study to meet the specific statutory requirements of this evaluation.

The Office of Strategic Finance (OSF) collaborated with three DHFS Divisions to collect data for selected outcomes. The Division of Health Care Financing extracted data from the Medicaid Management Information System and provided OSF with all records of emergency room use among the members of the cohort during the three-year study period. The Division of Supportive Living extracted data from the Human Services Reporting System (HSRS) to identify out-of-home placements among the members of the cohort during the three-year study period. The Division of Children and Family Services assisted OSF in collecting data on substantiated reports of child abuse and neglect from each POCAN Project's County Human Service Department and/or Department of Social Services.

This study did not employ an experimental design that included a control group. Such an approach would have required an assessment of risks among comparative populations and collecting outcome data among families that did not receive POCAN services. Comparative statistics regarding outcomes in other programs/populations are presented throughout this report as a source of general comparison only. For example, we provide data on substantiated child abuse/neglect report rates among all Wisconsin children age 0 to 3. These are not considered to be actual comparison groups because no data is available on the risks posed by these other populations. Consequently, we cannot control for risk level in analyzing the impact of POCAN on client outcomes. It is assumed that other populations that have outcome data available are of

substantially lower risk than the POCAN caseload, and it is expected that these populations would have more positive outcomes than would the high risk POCAN cases if they had not received POCAN services.

The tables in this report present descriptive and outcome data in aggregate and also broken out by various characteristics. Statistical tests were performed to determine if certain types of clients were more likely to be retained in the POCAN program through the end of follow-up. Statistical tests were also performed to determine if there was a significant improvement in strengthened family functioning and positive parenting practices during POCAN.

In all cases where the study concludes that a significant relationship exists between variables, a Chi-Square test was applied to the data and a minimum probability value of .05 was used. In all cases where the study concludes that the mean is significantly higher, a T-Test was performed and a minimum probability value of .05 was used. A smaller probability value indicates that more confidence can be placed in the conclusion that there was a significant relationship between variables. Actual probability values are reported in all cases where a significant relationship is concluded.

Description of the Study Cohort

POCAN Enrollments. The study cohort included a total of 236 POCAN cases enrolled by nine county projects during FY 2000. Caseloads for individual projects in the study cohort ranged from 9 to 53. The large range of caseloads was expected since project funding and capacity was based on each county's 1996 Medicaid birth rate and Medicaid birth rates vary considerably across the POCAN counties.

Client Case Composition. Projects collect information about the child, his or her parents and any other individual who plays an active role in the child's life and will be impacted by the POCAN activities. Those persons who assume a parenting role but are not the biological parent are referred to as parenting partners. All of the cases in the study cohort include a child and a mother. Nearly half (109 or 46%) of the cases in the cohort also include the child's biological father, and four cases also include a parenting partner.

Age of Child at Enrollment. The POCAN program attempts to enroll clients as close to the birth of the child as is feasible. Whenever possible, projects coordinate with county and local Medicaid-funded Prenatal Care Coordination (PNCC) programs. PNCC programs provide pregnancy-related assistance to Medicaid eligible pregnant women in locating and coordinating appropriate health and social services, and provide health education to improve birth outcomes. Coordination with PNCC programs helps POCAN programs to identify and establish relationships with pregnant women who will qualify for POCAN after the birth of their child and helps to provide a smooth transition to POCAN services for these women. For purposes of this study a client was classified as enrolled after they had been contacted in person or by phone three times by a project.

Many clients in the cohort were enrolled when children were very young. Some clients (24 cases or 10%) whose mothers had been contacted three times prior to their child's birth were enrolled on the child's birthdate. The average age of infants upon enrollment in the POCAN program was 2.6 months and the median age was 1.5 months. The vast majority (91%) of cases were enrolled before the child had reached 6 months of age. Only 5 cases were enrolled after the child had reached one year of age. The oldest child enrolled in the program was 29 months at enrollment.

Ages of Parents. The average age of mothers at the time they delivered their baby was 20. The youngest mother at delivery was 14 and the oldest was 43. About one-fourth (27%) of the mothers were under age 18 when they gave birth. The average age of mothers at the time of entrance into the POCAN program was also 20. The youngest mother was age 14 and the oldest was 43 at enrollment. Age data was missing on most (69%) of the fathers/parenting partners. Among those cases that had data on the age of the father/parenting partner, their age at the time of the child's birth ranged from 13 to 39, their average age at the child's birth was 23, and their average age at POCAN enrollment was 23.

Sex, Race and Ethnicity. Just over half (52%) of the children in the cohort are male. The majority of program participants are non-Hispanic whites. Among all enrollees in the cohort, 13% of the children, 7% of the mothers and 17% of the fathers/parenting partners were Hispanic. Data on race was missing for about half (51%) of the fathers/parenting partners.

Table 1
Racial Composition of Study Cohort

Race	Child	Mother	Father/Parenting Partner
White	78%	84%	68%
African American	6%	3%	10%
American Indian	7%	8%	10%
Asian	2%	2%	3%
Other	7%	3%	9%

Marital Status of the Mothers at Enrollment. Projects recorded marital status when clients enrolled in the program. Only five of the mothers were married upon POCAN enrollment. Projects are required to report marital status of mothers. Reporting of marital status data is optional for fathers/parenting partners and was rarely available. Marital status was reported for 197 of the mothers in the study group and for 31 of fathers/parenting partners in the study group.

Education Level of Parents at Enrollment. Projects were to report the educational status of both the mother and the father/parenting partner upon POCAN enrollment. Educational data was available on most (94%) of the mothers, but was missing for most (53%) of the fathers/parenting partners. The majority of parents enrolled in the POCAN projects had fewer than 12 years of education.

Table 2
Educational Status Upon POCAN Enrollment

Educational Status	Mothers	Fathers/Parenting Partners
Fewer than 12 years	51%	53%
GED	9%	8%
High School Graduate	34%	29%
Some College	6%	9%
Two Year Degree	0	1%
Four Year Degree	<1%	0

Employment Status of Parents at Enrollment. Projects were to report the employment status of both the mother and the father/parenting partner upon POCAN enrollment. Employment status data was available on most (97%) of the mothers, but was missing for many (41%) of the fathers/parenting partners. The majority of mothers in the study group were unemployed (59%) while the majority of fathers/parenting partners were employed full-time (58%).

Table 3
Employment Status Upon POCAN Enrollment

Employment Status	Mothers	Fathers/Parenting Partner
Unemployed	59%	25%
Employed Part-time	21%	17%
Employed Full-time	20%	58%

Risk Factor Assessments. In order to qualify for POCAN services, children must be shown to be at risk of abuse or neglect. Projects can document this risk through the client's Prenatal Care Coordination (PNCC) score or a score from DHFS' Family Questionnaire. PNCC is a Medicaid-funded benefit. POCAN Critical Element #2 directs that the POCAN Projects use a standardized assessment to identify families in need of services.

For clients receiving PNCC services, projects can use the scores recorded by the PNCC provider. If a client's PNCC score is not available or a client was not enrolled in PNCC, the POCAN Projects can use the PNCC assessment form to establish what the client's PNCC score would have been had they been screened for PNCC. A minimum score of 40 is considered to indicate a need for intervention. PNCC scores were reported for 127 of the cases in the cohort. The reported scores ranged from 40 to 441. The average PNCC score was 117.

The Family Questionnaire was developed by DHFS for administrating another Medicaid funded benefit, the Milwaukee County child care coordination benefit, and it also is an acceptable screening tool for assessing risk of abuse and neglect for the POCAN program. A family that scores 70 or above on this tool is assessed to be at risk and in need of intervention. A score of 150 or higher identifies families that are at high risk and in need of intensive services. Family Questionnaire scores (FQS) were reported for 138 cases in the study cohort. The mean FQS was 261 and scores ranged from 74 to 689. Most (89%) of the cases that were assessed with the FQS were classified as high risk and in need of intensive services.

It is important to note that the scores reported here may under-represent the need level of POCAN clients. Many of the questions on these risk scales require the collection of very personal information about past and current problems and family dysfunctionality. Assessments are done upon intake when POCAN staff are still attempting to build a trusting relationship with the client. Some projects indicate that they complete the PNCC or FQS tools for clients but stop scoring the risk factor assessments once the minimum score indicating a need for services has

been reached to minimize the need to ask intrusive, personal questions. Therefore, the risk levels of POCAN clients may actually be at a higher level than reported.

The counties that exclusively used the PNCC scale to assess risk were Manitowoc, Marathon and Waupaca. The counties that exclusively used the Family Questionnaire scale to assess risk were Door and Fond du Lac. Some Projects (i.e., Brown, Portage, Vernon and Waukesha) assessed the risk on some cases using both risk scales. Therefore, the total number of risk assessment scores reported exceeds the POCAN cohort caseload.

There was considerable variation in risk scores among POCAN Projects. On average, Brown and Portage County clients had the highest PNCC scores, with average risk scores of 215 and 209 respectively. These scores exceed minimum risk eligibility requirements by over 5 fold. On average, Portage, Brown and Door County clients had the highest FQSs, with average risk scores of 309, 299 and 298, respectively.

Table 4
Risk Scores Broken out by POCAN Project

County	PNCC Scores		Family Questionnaire Scores	
	Average	Range	Average	Range
Brown	215	106-416	299	94-689
Door	*	*	298	127-500
Fond du Lac	*	*	287	112-531
Manitowoc	64	40-133	*	*
Marathon	126	41-294	*	*
Portage	209	48-441	309	178-585
Vernon	121	63-250	223	74-387
Waukesha	140	55-255	162	115-175
Waupaca	84	42-207	*	*
Statewide	117	40-441	261	74-689

* This scale was not used by this POCAN Project.

Findings: Legislatively Mandated Outcomes

Substantiated Reports of Child Abuse and Neglect. POCAN legislation requires that the Department report on the number of substantiated child abuse and neglect reports in the POCAN population. The data reported here reflects data collected from the local County Human Service Department (HSD) and/or Department of Social Services (DSS). Each of the 9 POCAN counties that were studied were surveyed regarding substantiated child abuse and neglect reports. The Division of Children and Family Services assisted OSF in obtaining county data on substantiated child abuse and neglect reports among the POCAN cohort.

The data reported on substantiated child abuse and neglect only includes reports that were made in the same county that enrolled the family in POCAN. If the family moved to a different county and had a substantiated report there, we are not able to identify and report this data. During the study's follow-up period, the Department did not have a statewide database that identified the specific children that were victims of abuse/neglect. Child abuse and neglect report data is highly confidential and it was not practical to survey all counties in the state regarding these reports. Counties currently report data regarding the findings of all child abuse and neglect reports to DHFS; however, the victim's anonymity is maintained. The Department is currently implementing a statewide information system,[4] which will identify and track abused and neglected children.

There were 11 substantiated reports of child abuse and/or neglect among the POCAN study cohort while they were active POCAN clients. Ten children (4% of the cohort) were found to have been abused and/or neglected while receiving POCAN services. The nature of these findings were:

- Child Neglect - 6 children (1 report per child)
- Physical Abuse - 1 child (1 report)
- Physical Abuse and Child Neglect - 3 children (2 children with 1 report and 1 child with 2 reports)

We also determined that there were 2 substantiated reports of child abuse and neglect following POCAN closure. Both of the reports that were made post-POCAN had a finding of neglect.

In addition, there were 4 children that were found to be at risk of abuse and/or neglect during POCAN participation. Three of these reports concluded a risk of neglect and one concluded a risk of physical abuse. There was also one child that was found to be at risk of physical abuse post-POCAN closure. In all of these at risk cases, the investigation concluded that the child had not been abused or neglected yet, but the county found that "abuse or neglect is likely to occur."

Table 5 summarizes detailed information regarding substantiated child abuse and neglect reports during or post POCAN. An arbitrary identification number was created to present this data to

[4] The Wisconsin State Automated Child Welfare Information System (WiSACWIS) will collect and maintain statewide child abuse/neglect data on a child specific basis. Currently, WiSACWIS has been implemented in 39 counties, and full statewide implementation is anticipated by June 2004.

preserve the anonymity of the child. In those cases where there were multiple substantiated child abuse and neglect reports on a child, each line represents a separate substantiated report and reports are presented in chronological order.

Table 5
Substantiated Reports of Child Abuse and Neglect Among Children Enrolled by POCAN

Project and Child	Type of Abuse or Neglect	Relationship Of Maltreater	Risk Level of Family[5]	Timing of Report
Brown #I	Neglect	Mother	High (FQS=480)	During POCAN
Brown #II	Neglect	Mother	High (FQS=286)	During POCAN
Brown #III	Physical Abuse	Father	High (FQS=291)	During POCAN
	Physical Abuse & Neglect	Mother & Father		During POCAN
Door #I	Physical Abuse & Neglect	Mother	High (FQS=340)	During POCAN
Fond du Lac #I	Physical Abuse	Mother	High (FQS=531)	During POCAN
Fond du Lac #II	Neglect	Mother	Low (FQS=128)	During POCAN
Manitowoc #I	Neglect	Mother and Grandmother	Low (PNCC=75)	During POCAN
Marathon #I	Neglect	Mother & Father	High (PNCC=121)	During POCAN
Marathon #II	Physical Abuse & Neglect	Step-brother (abuse) and Mother (neglect)	High (PNCC=149)	During POCAN
	Neglect	Mother		Post-POCAN
Marathon #III	Neglect	Mother	High (PNCC=138)	Post-POCAN
Portage #I	Neglect	Mother	High (PNCC=196)	During POCAN

The incidence of substantiated child abuse and neglect reports among POCAN families by county during POCAN participation was: Brown County – 3 children (4 reports), Door County - 1 child, Fond du Lac County – 2 children, Manitowoc County - 1 child, Marathon County – 2 children, and Portage County – 1 child. None of the children from the Vernon, Waukesha or Waupaca County POCAN cohorts had any substantiated or at risk child abuse and neglect reports during POCAN participation.

[5] FQS is the Family Questionnaire Risk Score. PNCC is the Prenatal Care Coordination Risk Score. Families with a risk score above the POCAN median were defined as “higher risk”. Any family with a FQS at or above 237 or a PNCC at or above 100 was defined as “higher risk”.

The children that had substantiated reports of abuse/neglect during POCAN were from families with extremely high risk scores. Eight of the ten children that had substantiated reports of abuse/neglect during POCAN participation were from families that had risk scores above the POCAN median risk score. On average, the PNCC score among these abuse/neglect victims was 135 (N=4) and the Family Questionnaire score among these abuse/neglect victims was 343 (N=6). In comparison, among the children without substantiated reports of abuse/neglect, the average PNCC score was 117 and the average Family Questionnaire score was 258.

During the POCAN follow-up period starting with POCAN enrollment during FY 2000 and through June 30, 2002, there were 13 substantiated reports of child abuse and/or neglect among 11 children from the POCAN cohort. This includes two reports following POCAN closure.

It should be noted that POCAN staff are mandatory reporters of child abuse and neglect. POCAN home visitor staff are in frequent and intensive contact with families. This increased surveillance may have led to additional and more expeditious reporting of child abuse and neglect, and consequently higher child abuse and neglect rates among the POCAN cohort as compared with young children statewide.

The study identified the statewide incidence of substantiated CAN reports among young Wisconsin children age 0 to 3 and compared this rate with that experienced among POCAN children during POCAN participation. During CY 2001, there were 2,367 substantiated CAN reports among children age 0 to 3 statewide. This represents a CAN incidence rate of 0.87% during the 12 months in 2001. The study cohort was enrolled in POCAN for an average of 18 months and to compare statewide outcomes during a similar time period, the statewide CAN rate during 2001 was multiplied by 1.5. Therefore, over a similar 18-month period equivalent to the average follow-up period used in the POCAN evaluation, the statewide child abuse/neglect incidence rate among children age 0 to 3 was estimated to be 1.3%.

This data reflects substantiated abuse/neglect among the state's entire age 0 to 3 population, most of whom are not at risk of child abuse and/or neglect. The national "KIDS COUNT" Project[6] estimates that in CY 2000, 8% of all Wisconsin children were living in "high risk families". This is based on 4 indicators of child well being[7] that were extracted from the 2000 census.

Other studies have identified risk factors associated with child abuse/neglect. The Third National Incidence Study on Child Abuse and Neglect[8] concluded that children living in poverty were 22 times more likely to experience abuse/neglect. This study also concluded that children in single

[6] The Annie E. Casey Foundation, KIDS COUNT Special Report Children at Risk State Trends 1999-2000", 2002. This is an annual report that uses census data to track the health and well being of children on a state by state basis.

[7] These indicators include: family income below poverty level, single parent family, no parent has full time year round employment and head of household is a high school dropout. Any child living in a household where 3-4 of these indicators is present is defined as high risk.

[8] Sedlak, A. and Broadhurst, D. Third National Incidence Study of Child Abuse and Neglect (NIS-3): Executive Summary. Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 1996.

parent families had a 120% higher risk of abuse/neglect. Virtually all POCAN children have these two risk factors.

All families enrolled by POCAN are high risk and the vast majority are of very high risk. Among the POCAN cases that were assessed using the PNCC risk instrument, the average PNCC score was 117, which is nearly triple the PNCC risk threshold. Among the POCAN cases that were assessed with the FQS, 89% were classified as high risk and in need of intensive services. On average, these cases had a FQS of 261, which is nearly quadruple the risk threshold. Some POCAN families had risk levels at 10 times the risk threshold.

Child abuse/neglect outcomes must be evaluated relative to the risk level of the child's environment. While POCAN children had a higher child abuse/neglect incidence rate than the general population, relative to their risks, they had a lower substantiated child abuse/neglect rate than would have been expected without POCAN intervention. All at risk children are not abused/neglected. While 8% of the Wisconsin juvenile population is defined as being "at risk", the projected substantiated statewide child abuse/neglect incidence rate over an equivalent 18-month period was considerably lower at 1.3%.[9]

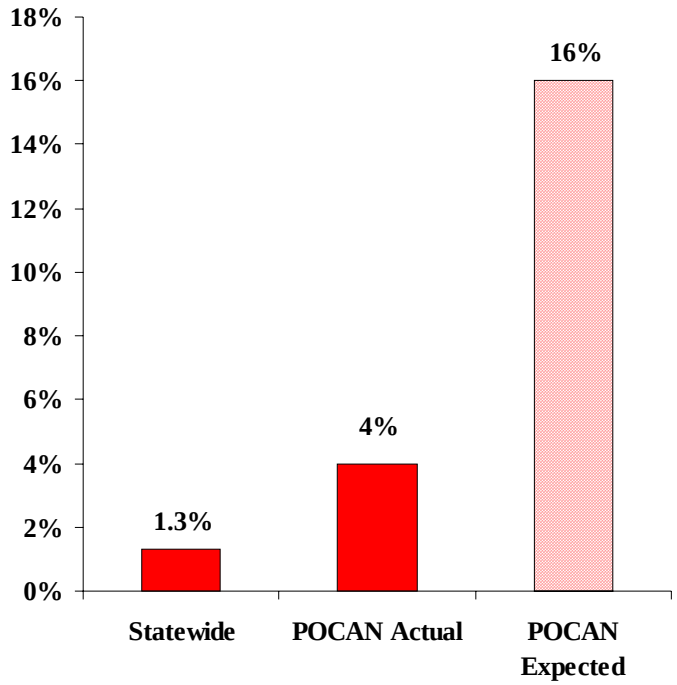
While it is not possible to establish a firm measure of the anticipated substantiated child abuse/neglect report rate of the POCAN caseload, estimates can be made to determine what their substantiated child abuse/neglect report rate might have been without POCAN intervention. For example, if data on the relative risk level[10] of POCAN children are applied to the actual statewide incidence of substantiated child abuse/neglect, one might estimate that the substantiated CAN report rate of POCAN cases could have been 12.5 times that experienced by the general juvenile population, or up to 16%[11] without POCAN intervention. This suggests that the CAN rate among POCAN children could have been about quadruple what they actually experienced if they had not received POCAN services (i.e., 16% instead of the 4% actual rate).

[9] To project the statewide child abuse/neglect rate over an equivalent 18-month time period, the actual 12 month child abuse/neglect rate of .87 was multiplied by 1.5.

[10] Assuming that 100% of POCAN children are at risk, the risk level of the POCAN cohort is 12.5 times the 8% statewide risk level, based on KIDS COUNT estimates of 8% risk level statewide.

[11] The expected child abuse/neglect rate among POCAN children without intervention is based on multiplying the actual statewide child abuse/neglect rate of 1.3% by a factor of 12.5% (i.e., the increased risks posed by POCAN).

Figure 1
Incidence of Child Abuse and Neglect Among POCAN Children (Actual vs. Expected)
as Compared to Children Age 0 to 3 Statewide – 18 Month Time Period



Emergency Room Visits During POCAN. The study is required to report on the incidence of emergency room visits due to injuries among POCAN children. We report data on emergency room visits due to injuries and also report visits due to illnesses, which are a far more common reason for emergency room use. Both outpatient emergency room use and emergency room visits that resulted in an inpatient admission were identified.

Data on emergency room visits was obtained from the Medicaid database. This was done to assure that the study thoroughly captured data on emergency room use during POCAN participation, and to allow the study to report specific data as to the medical problems presented at the emergency room. The International Classification of Diseases (ICD-9) codes recorded by the attending physician were analyzed to report on the nature of the child's medical problems. The emergency room use record always reported a primary diagnostic code as the reason for the visit, and often times also reported other medical conditions that were present, but that may or may not have been related to the primary reason for the emergency room visit. For example, the primary diagnosis could be ear infection and the secondary related diagnoses could be fever or a secondary unrelated diagnosis could be eye infection. In those cases where the emergency room visit was due to illness, only the primary reason for the visit as recorded by the physician is reported as the reason for the emergency room use. All recorded diagnostic codes are reported for emergency room visits due to injury.

Just over one-fourth (69 or 29%) of the children in the cohort used an emergency room during POCAN. There were 137 emergency room visits among these 69 children. The majority (54%) of

children had only one visit to the emergency room. The remaining children who used an emergency room had between 2 and 10 visits. Most (53 children or 77%) clients that used an emergency room were seeking medical care solely due to illness. Six children from the cohort were brought to an emergency room solely to receive treatment due to injuries, and in ten cases, the child was brought to an emergency room to receive treatment for an illness and also brought in on another date to receive treatment due to injury.

The vast majority (93%) of emergency room visits were resolved on an outpatient basis. There were 9 cases where the child's medical problems were judged to be so severe that they required a hospital inpatient admission.

Emergency room use varied among clients served by the POCAN Projects. Brown County had the greatest number (18) of clients that used an emergency room; however, they also made up a disproportionate share of the cohort. Brown County's rate (34%) of emergency room use was only slightly higher than the statewide average of 29% among the cohort. Door County had the highest rate of emergency room use during POCAN, with 56% of their cohort using an emergency room.

Table 6
Emergency Room Use During POCAN

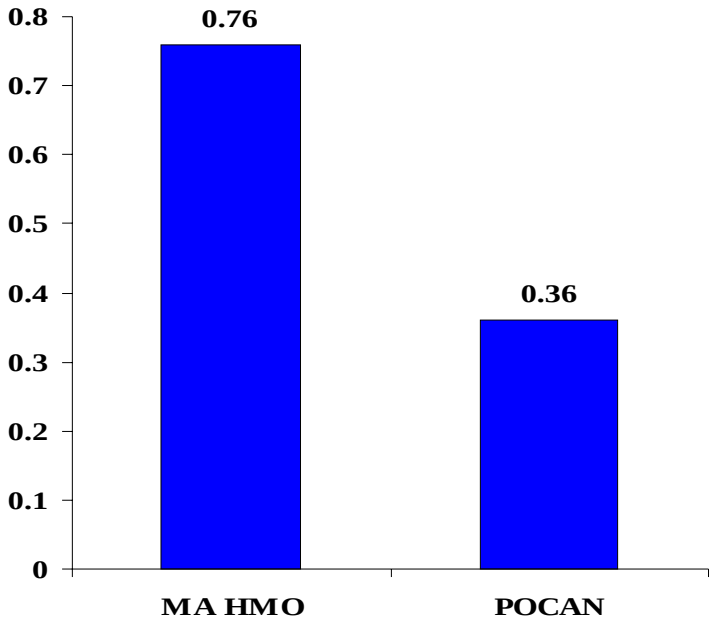
POCAN Project	# that Used an Emergency Room Due to Illness Only	# that Used an Emergency Room Due to Injury Only	# that Used an Emergency Room Due to Both Illness and Injury	Total # of Clients that Used an Emergency Room	% of Cohort that Used an Emergency Room
Brown	11	1	6	18	34%
Door	4	0	1	5	56%
Fond du Lac	7	1	0	8	32%
Manitowoc	7	0	0	7	23%
Marathon	6	1	0	7	16%
Portage	1	1	0	2	13%
Vernon	2	0	0	2	18%
Waukesha	8	2	3	13	41%
Waupaca	7	0	0	7	41%
Statewide	53	6	10	69	29%

As a general comparison, The Wisconsin Medicaid HMO Comparison Report found that in 1999, there were 47,461 emergency room visits without an inpatient admission among all MA eligible children age 0-5 served through Wisconsin HMOs. This represents 0.76 emergency room visits

per MA eligible year.[12] Among POCAN clients, the comparable annual emergency room visit rate was 0.36.[13]

The study also tracked the prevalence of primary care physicians among POCAN clients and found that the vast majority (98%) had a primary care physician. The availability of primary care physicians among children in the cohort may have acted to reduce emergency room use. POCAN staff are also responsible for educating families on appropriate use of emergency rooms, and this may have contributed to POCAN's lower rate of emergency room services.

Figure 2
Emergency Room Use Among POCAN Children
as Compared with Medical Assistance Recipients (Age 0 to 5) Statewide Served Through HMOs



Emergency Room Use Due to Injuries. There were 16 children (7% of the cohort) who visited an emergency room to receive treatment for an injury during POCAN. These children had 23 emergency room visits due to injuries. Twelve of these children had only one emergency room visit for an injury, and four visited the emergency room multiple times to receive treatment for injuries.

The incidence of emergency use due to injury among POCAN families by county during POCAN participation was: Brown County – 7 children, Door County - 1 child, Fond du Lac County – 1 child, Marathon County – 1 child, Portage County – 1 child and Waukesha County – 5 children.

[12] "Eligible year" prorates emergency room use to account for the number of months that each client was eligible for MA during that year.
[13] POCAN annualized emergency room use rate was based on 128 emergency room visits without an inpatient admission among POCAN clients during the three-year follow-up period, and an average time on POCAN of 18 months.

None of the children from the Manitowoc, Vernon or Waupaca County POCAN cohorts had any emergency use due to injury during POCAN participation.

Table 7 presents data on all medical problems presented during these emergency room visits. An arbitrary identification number was created to present this data on injuries to prevent the identification of the child. In those cases where the child had multiple emergency room visits, each line represents a separate emergency room visit and diagnostic data is presented in chronological order. In all but one of these cases, the injury was treated on an outpatient basis at the emergency room and the child was sent home. One child was admitted to a hospital for inpatient treatment as a result of an injury related emergency room visit.

Table 7
Emergency Room Use Due to Injuries During POCAN

Project and Child	Primary Diagnosis	Diagnosis #2	Diagnosis #3	Diagnosis #4
Brown #1	Car Accident			
Brown #2	Finger Wound			
Brown #3	Forehead Wound			
Brown #4	Elbow Sprain	Sore Throat	Respiratory Infection	Virus Infection
	Lip Wound			
	Follow-up Exam			
Brown #5	Foot Burn/Abrasion			
	Face Bruise			
	Scalp Wound			
Brown #6	Face Bruise	Respiratory Infection	Insect Bite	Accidental Fall
Brown #7	Eye Wound			
Door #1	Finger Wound			
Fond du Lac#1	Face Bruise			
	Car Accident			
	Eye Wound			
Marathon #1	Skull Fracture			
	Battered Baby*	Skull Fracture	Broken Arm	Eyeball Bruise
Portage #1	Poisoning (Tranquilizers)			
Waukesha #1	Face Bruise	Lip Wound		
Waukesha #2	Head Injury			
Waukesha #3	Lip Wound			
Waukesha #4	Poisoning (Non-Drug)	Vomiting		
Waukesha #5	Dislocated Elbow			

*This child also was diagnosed with hypertension and a pituitary gland disorder during this emergency room visit, and was admitted to the hospital as an inpatient.

Children in families with assessed risk levels above the median risk score were much more likely to visit an emergency room to receive treatment for an injury than were children in families with assessed risk levels below the median risk score, although this difference was not great enough to be statistically significant. It was found that 83% of emergency room use due to injury was among children in families with assessed risk levels above the median risk score.

Emergency Room Use Due to Illness. There were 63 children who visited an emergency room to receive treatment for illness during POCAN. These children had 114 emergency room visits due to illness. Most (37 of 63 or 59%) of these children had only one emergency room visit for an illness, and 26 visited the emergency room multiple times (2 to 7 times) to receive treatment for illness. Most of these children were treated on an outpatient basis at the emergency room and the child was subsequently sent home. Eight of these children were admitted to the hospital due to illness.[14]

The most common reason for an emergency room visit was respiratory virus infections, accounting for 25% of all illness related emergency room visits. Ear infections were also a common reason for an emergency room visit, accounting for 21% of all illness related emergency room visits. The primary reasons for emergency room visits due to illnesses, based on the primary diagnosis recorded by the attending physician, are reported in Table 8.

Table 8
Emergency Room Use During POCAN Due to Illnesses

Primary Diagnosis	# of Visits
Respiratory Virus Infection	29
Ear Infection	24
Chills and Fever	15
Gastrointestinal Problem	10
Bronchitis	8
Skin Disorder	7
Pneumonia	4
Croup	4
Influenza	2
Eye Infection	2
Kidney Infection	1
Asthma	1
Sneezing/Choking	1
Limb Pain	1
Allergies	1
Headache	1
Teething	1
Feared Complaint, No Specific Diagnosis	1
Other Observation	1

[14] The illness diagnoses that resulted in hospitalization were: influenza (primary diagnosis) with fever, dehydration and ear infection; throat abscess; croup; disease of the trachea/bronchus; bronchitis (primary diagnosis) with pneumonia and ear infection; fever (primary diagnosis) with sinus infection and jaundice; and fever (2 cases).

Children in families with assessed risk levels above the median risk score were more likely to visit an emergency room to receive treatment for an illness than were children in families with assessed risk levels below the median risk score, although this difference was not great enough to be statistically significant. It was found that 65% of emergency room use due to illness was among children in families with assessed risk levels above the median risk score.

Out-of-Home Placements. The POCAN legislation requires that the Department report on the number of out-of-home placements in the POCAN population. The Child Substitute Care Module of the Department's Human Services Reporting System (HSRS) was queried to identify all out-of-home placements among the cohort. County HSDs and DSSs are to report data on HSRS regarding all out-of-home placements that involved a payment. The POCAN Projects were also asked to identify any out-of-home placements that occurred during POCAN participation. They identified the court ordered out-of-home placements that were included on HSRS, as well as informal placements with family members and short-term respite care placements that occurred during POCAN participation. It is possible that there were additional informal out-of-home placements of POCAN clients that POCAN staff may not have been aware of and that were also not reported on HSRS, which only tracks formal placements.

Twenty children (8% of the cohort) were in an out-of-home placement at some point during their POCAN participation.

- **Formal Out-of-Home Placements.** Eight of these 20 children were formally placed in the out-of-home setting by the courts and the County HSD/DSS paid for the placement. Seven of these eight children were ordered to the placements due to abuse and/or neglect, and the remaining court-ordered placement was due to a voluntary adoption.
- **Informal Out-of-Home Placements.** Twelve of these 20 children had informal placements that had no payment costs reported on HSRS. The Projects reported two children that were placed in short-term respite care, four children that were voluntarily placed with their grandmother and six cases where a Children in Need of Protective Services petition (CHIPS) had been filed with the courts on the child's behalf due to abuse and/or neglect. In these areas, the child was put in an out-of- home placement but no county costs were reported on HSRS.

On average, these families had higher risk scores at intake than the families that did not have out-of-home placements, although the difference was not great enough to be significant. Among the families with out-of-home placements, Family Questionnaire scores averaged 319, and among the families without out-of-home placements, Family Questionnaire scores averaged 254. In all but one case where there was an out-of-home placement and the family had been assessed using the Family Questionnaire, the risk score was high enough to be classified as "high risk."[15] Among the families with out-of home placements, PNCC scores averaged 155, and among the families without out-of home placements, PNCC scores averaged 115.

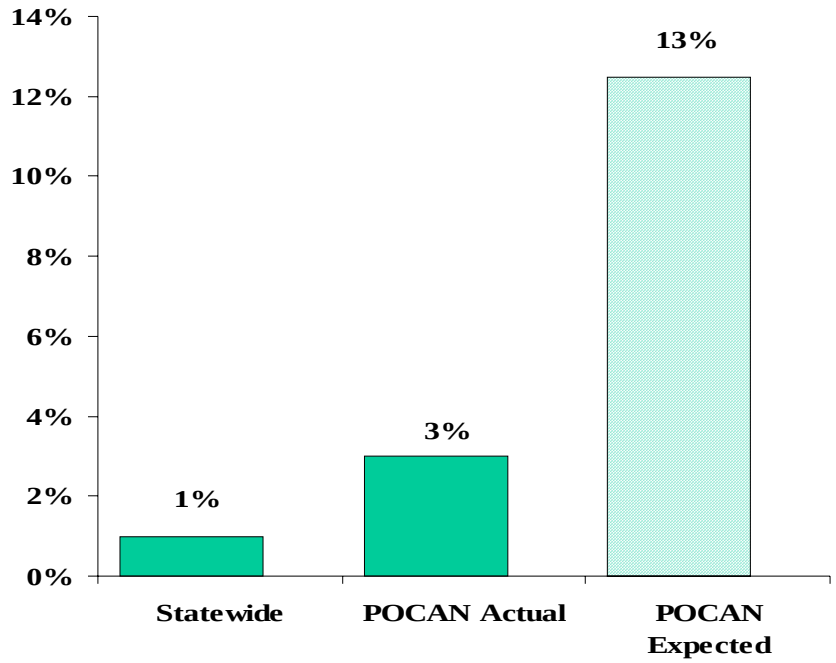
The POCAN projects that enrolled the families that had out-of-home placements were: Brown County - 6, Door County - 1, Fond du Lac County – 5, Marathon County – 3, Portage County –

[15] A FQS at or above 150 is classified as "high risk".

1; Waukesha County – 3; and Waupaca County –1. None of the children from the Manitowoc or Vernon County POCAN cohorts had any out-of-home placements during POCAN participation.

The study identified the statewide incidence of out-of-home placements among young Wisconsin children age 0 to 4 and compared this rate with that experienced among POCAN children during POCAN participation. Statewide, during CY 1999, 0.7% of children age 4 and under entered a formal out-of-home placement that was reported on HSRS. If the 1999 rate were used to project the out-of-home placement rate over an 18-month period similar to the average time on POCAN, one would estimate that the statewide formal out-of-home placement rate would be 1%. Among the POCAN caseload, 3% entered a formal out-of-home placement that was reported on HSRS during POCAN. As discussed earlier, the POCAN caseload poses higher risk levels than the general juvenile population, and one would expect their out-of-home placement rate to also be higher than the general population without POCAN intervention. We projected the expected POCAN placement rate without intervention by applying the statewide rate to the higher risk level among POCAN children (i.e., 12.5 times higher risk level). It was concluded that the out-of-home placement rate among POCAN children could have been about quadruple what they actually experienced if they had not received POCAN services (i.e., 13% instead of the 3% actual).

Figure 3
Out-of-Home Placements Among POCAN Children (Actual vs. Expected)
as Compared with Children Age 0 to 4 Statewide

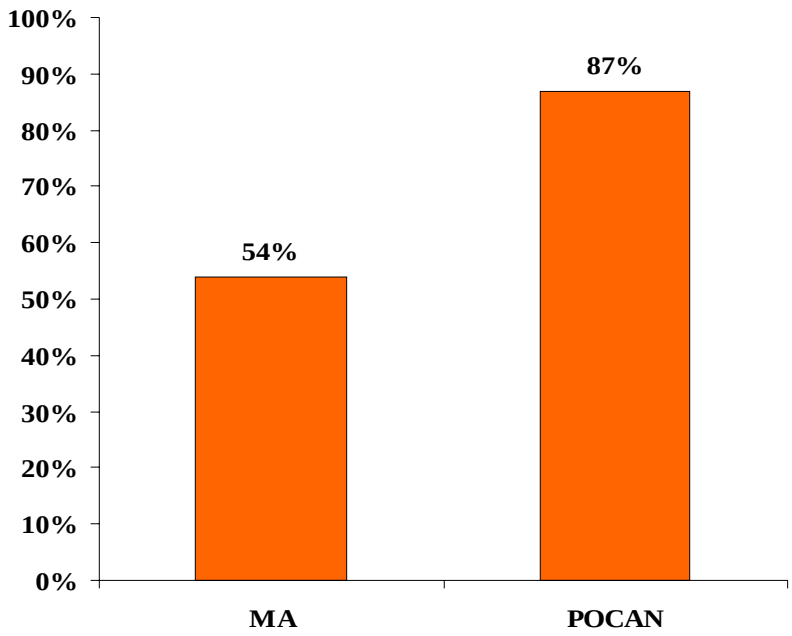


Immunizations. Projects reported whether children were up to date on their immunizations, and if they were not, whether the child had an illness that required delaying a vaccination. Data on

the status of immunizations was available on 94% of the cohort (223 children). Most (87%) children with this data were reported to have received all scheduled immunizations while on POCAN. Projects reported that in 12 cases, the child's immunizations were delayed due to illness. Among the 29 children who were reported to have missed any immunizations, the number missed was: 9 missed 1 immunization, 10 missed between 2 and 8 immunizations, and 10 children missed an unknown number of immunizations.

As a general comparison, 54% of MA eligible two-year olds had received all scheduled immunizations.[16] The Department's Division of Public Health Maternal and Child Health Block Grant Application has set its goal for vaccination completion[17] for 2001 at 78%. The POCAN completed immunization rate among children in the cohort met this goal.

Figure 4
Immunization Rates Among POCAN Children
as Compared with Medical Assistance Recipients (Age 2) Statewide



HealthCheck Exams. HealthCheck is Wisconsin's name for the federally mandated Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children under 21. HealthCheck has established a periodicity schedule for comprehensive health screening (HealthCheck) exams. This periodicity schedule has been recommended by the American

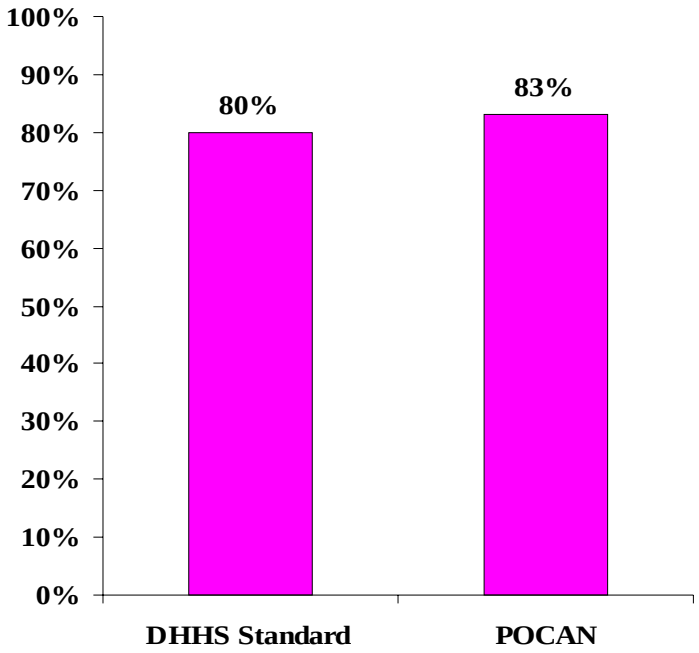
[16] Cases in the MA sub-population were restricted to those MA children that were MA eligible in CY 2001, age 19 to 35 months as of 1/1/2002, had at least 10 months of continuous MA eligibility prior to age 19 months and had data on the Wisconsin Immunization Registry. 63% of the MA cases that were age eligible for this comparison met continuous eligibility criteria and also had an immunization record.
[17] Scheduled immunizations include Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

Academy of Pediatricians. POCAN critical element #7 states that all families should be linked to a health care provider and services. Early initiation of health care services and the provision of health screening and immunization services help prevent long-term health related problems.

Projects reported whether children were up to date on their HealthCheck exams. Data on the status of HealthCheck exams was available on 87% of the cohort (206 children). Most (83%) children with this data were reported to have received all scheduled HealthCheck exams while on POCAN. Among the 36 children who were reported to have missed any HealthCheck exams, the number missed was: 14 missed 1 HealthCheck exam, 17 missed between 2 and 6 HealthCheck exams, and 5 children missed an unknown number of HealthCheck exams.

The Federal Department of Health and Human Services requires that 80% of MA eligible children receive all scheduled Health Check exams. Wisconsin's Medicaid managed care contract requires that 80% of eligible and enrolled children receive all scheduled HealthCheck exams. POCAN clients met both the Federal and Wisconsin MA HMO contract standards.

Figure 5
POCAN Health Check Exam Rates as Compared with Federal Medical Assistance Standards



Developmental Screens. The Department is required to evaluate enhanced child development among POCAN clients. Developmental screening tools were used to analyze child development and to assess whether children were within developmental norms. In those cases where the child was not within developmental norms, a referral to the federally mandated Birth to 3 early intervention program should be made to maximize the child's development. Projects were required to report whether screens had been done, whether children were within developmental

norms and which screening tools they used. In those cases where the child was not within developmental norms, the evaluation tracked whether the child was referred to the Birth to 3 Program and whether the child received services.

Projects reported that 205 children (87% of the cohort) had been screened. Projects reported using the Ages and Stages instrument for 53% of the children, the Denver instrument for 30%, a combination of these instruments for 14% and other types of screens such as by the primary care physician for the remaining 3% of the children.

The children in the POCAN cohort had a relatively high rate of developmental delays as compared with children statewide.[18] There were 26 POCAN children who were identified as having developmental delays. This represents 13% of the children who were screened. Most (25 of 26) of these children were referred to the Birth to 3 Program. Twenty children (8% of the cohort) received Birth to 3 services. In one case, the parents were opposed to receiving services through the Birth to 3 Program, and refused the referral and in the other cases, the parents failed to follow-through on the referral.

Strengthened Family Functioning and Positive Parenting Practices. The POCAN enacting legislation requires the Department to measure "strengthened family functioning and positive parenting practices" of participants. To measure this outcome, the study tracked scores from the Home Observation for Measurement of Environment (HOME) instrument. The HOME is an accepted and widely used tool that provides a description of a child's primary environment, including parental behaviors. It has been used in over 400 studies worldwide. POCAN Projects were required to administer the HOME to clients at three points in time, specifically when the child was 6, 12 and 18 months of age. The change in HOME scores over time was used by the POCAN evaluation to determine the effectiveness of the program in improving family functioning and parenting practices to enhance a child's primary environment and promote age-appropriate child development. A copy of the HOME assessment instrument is included in Appendix D.

The number of HOME assessments that were due on each case varied depending on the age of the child at POCAN enrollment and whether the case was closed prior to the child reaching 18 months of age. If the child was under 6 months at enrollment, and over 18 months at closure or still active at the end of follow-up, all three HOME assessments should have been completed. Among all cases, 9% of the children were over 6 months old at enrollment. Among the closed cases, 105 children were under 18 months old at closure. As a result, all three HOME assessments were generally not completed for those cases where the child was over 6 months old at enrollment or under 18 months old at closure. In addition, there were some cases where the POCAN Projects failed to complete the HOME assessment at the appropriate interval.
Only about one-third (35%) of the cohort had all three HOME assessments completed. About one-fourth (26%) never received a HOME assessment, 55 cases (23%) had only one HOME assessment and 38 cases (16%) had two HOME assessments completed. Therefore, the study is only able to report data on strengthened family functioning and positive parenting practices

[18] As of 12/1/01, the Birth to 3 program was serving 2.6% of all Wisconsin children, age 0 to 3.

among 121 families (51% of the cohort) since this is the number of families that have over one HOME assessment. For those cases with fewer than two HOME assessments completed, we report their HOME assessment scores only for descriptive purposes of family functioning and positive parenting practices because data limitations prevent the analysis of change.

About two-thirds (148 families or 63%) of the cohort had a HOME assessment at 6 months. About half (127 families or 54%) had a HOME assessment at 12 months and 44% of the cohort (105 families) had had a HOME assessment at 18 months. The study analyzed the degree of change between the HOME scores during each 6 month increment where consecutive HOMES were available (i.e., 6 vs. 12 months HOME scores and 12 vs. 18 month HOME scores). In addition, in those cases where both a 6 and 18 month HOME assessment was done, the study analyzed the change in the HOME score during this entire time frame.

HOME Assessments on All POCAN Families. Each time the HOME Assessment instrument is administered, the total HOME score can range from 0 to 45. Higher HOME scores indicate better parenting practices and family functioning. Among all families that had any HOME assessments, HOME scores averaged 34.1 at six months, 35.4 at 12 months and 36.3 at 18 months. Among all families that were assessed, the HOME scores at 6 months ranged from 16 to 44, the HOME scores at 12 months ranged from 14 to 44, and the HOME scores at 18 months ranged from 15 to 44.

Table 9
Average HOME Scores Among All POCAN Cases

HOME Score Components	Range of Possible Scores	Average 6 Month HOME Scores (N=148)	Average 12 Month HOME Scores (N=127)	Average 18 Month HOME Scores (N=105)
Responsivity	0-11	8.8	9.2	9.6
Acceptance	0-8	6.1	5.6	5.6
Organization	0-6	4.9	5.0	5.1
Learning Materials	0-9	6.8	7.8	7.9
Involvement	0-6	4.3	4.3	4.4
Variety	0-5	3.1	3.5	3.6
Total HOME Score	0-45	34.1	35.4	36.3

It should be reiterated that the preceding data is primarily descriptive as it includes some families that only had one HOME assessment. Consequently, the data presented in Table 9 cannot be analyzed statistically to draw conclusions about changes in family functioning and positive parenting practices. Only the cases with multiple assessments can be analyzed to measure improvements in family functioning and positive parenting practices.

HOME Assessments by County. The study analyzed total HOME scores by individual project. All HOME scores that were available were included in this analysis. Data on HOME scores by county is provided for descriptive purposes only since some cases with only one assessment are included in the database. This data cannot be analyzed statistically to draw conclusions about

changes in family functioning and positive parenting practices. Only the cases with multiple assessments can be analyzed to measure improvements in family functioning and positive parenting practices.

Table 10
Average Overall HOME Scores at 6, 12 and 18 Months, by County

POCAN Project	Average 6 Month HOME Scores	Average 12 Month HOME Scores	Average 18 Month HOME Scores
Brown	32.2 (N=34)	33.9 (N=36)	34.1 (N=29)
Door	33.5 (N=8)	34.0 (N=5)	33.8 (N=4)
Fond du Lac	32.8 (N=16)	32.3 (N=13)	31.0 (N=9)
Manitowoc	35.6 (N=17)	37.8 (N=16)	37.9 (N=15)
Marathon	31.2 (N=15)	34.7 (N=11)	36.2 (N=13)
Portage	36.4 (N=16)	37.4 (N=14)	39.6 (N=8)
Vernon	37.0 (N=8)	40.6 (N=5)	37.8 (N=5)
Waukesha	37.0 (N=24)	37.4 (N=16)	40.3 (N=12)
Waupaca	31.5 (N=10)	34.4 (N=11)	37.7 (N=10)
Statewide	34.1 (N=148)	35.4 (N=127)	36.3 (N=105)

Changes in HOME Assessments Among POCAN Families with Multiple Assessments. Among the 121 POCAN families that had multiple HOME assessments, 83 (69%) had all three HOME assessments, 22 (18%) had only the 6 and 12 month HOME assessments, 11 (9%) had only the 12 and 18 month HOME assessments, and 5 (4%) had only the 6 and 18 month HOME assessments. In all cases where data was available from multiple assessments, the study compared the scores at each of these points in time to assess the impact of POCAN on strengthened family functioning and positive parenting practices.

Comparison of HOME Assessments at 6 and 12 Months

There were 105 families that had both a 6 and 12 month HOME assessment. In comparing the 6 and 12 month HOME scores, it was found that the overall HOME score improved by 2 points (a 6% increase), on average. This change in HOME scores is statistically significant.[19] Scores on four of the six dimensions (i.e., responsivity,[20] organization,[21] learning materials[22] and variety[23]) of the HOME assessment scale showed statistically significant improvements. The biggest improvement was in the availability of learning materials for the child, which improved by 1.2 points (18%) between the point when the child was 6 and 12 months old. There was no change in the involvement dimension (i.e., parental involvement with the child) of the HOME assessment, and the acceptance dimension deteriorated by .4 points (7%). Most (65 or 62%)

[19] P=.0001 and T-Value=4.30.
[20] P=.0008 and T-Value=3.46
[21] P=.0146 and T-Value=2.48
[22] P=.0001 and T-Value=6.76
[23] P=.0008 and T-Value=3.45

families had higher overall HOME scores at 12 months as compared with at 6 months, 9% remained the same and 29% had lower scores.

Table 11
Average HOME Scores Among POCAN Cases that Have Both a 6 and 12-Month Assessment

HOME Score Components	Range of Possible Scores	Average 6 Month HOME Scores	Average 12 Month HOME Scores
Responsivity	0-11	8.7	9.3
Acceptance	0-8	6.0	5.6
Organization	0-6	4.8	5.1
Learning Materials	0-9	6.8	8.0
Involvement	0-6	4.4	4.4
Variety	0-5	3.2	3.5
Total HOME Score	0-45	34.0	36.0

Comparison of HOME Assessments at 12 and 18 Months

There were 94 families that had both a 12 and 18 month HOME assessment. In comparing the 12 and 18-month HOME scores, it was found that on average, the overall HOME score remained stable at 36.4.

Table 12
Average HOME Scores Among POCAN Cases that Have Both a 12 and 18-Month Assessment

HOME Score Components	Range of Possible Scores	Average 12 Month HOME Scores	Average 18 Month HOME Scores
Responsivity	0-11	9.4	9.6
Acceptance	0-8	5.8	5.6
Organization	0-6	5.1	5.1
Learning Materials	0-9	8.0	8.0
Involvement	0-6	4.5	4.4
Variety	0-5	3.6	3.6
Total HOME Score	0-45	36.4	36.4

There was no significant change in the total HOME score or in any individual dimension of the HOME assessment between the point when the child was 12 and 18 months old. Average scores on the responsivity dimension, which measures parental responsivity to the child, improved by 0.2 points (2%). Average scores on the organization, learning materials and variety dimensions remained the same. There was an insignificant deterioration in the acceptance and involvement dimensions (down by 0.2 and 0.1 points, respectively) of the HOME scale between 12 and 18

months. It was found that 39 families (42%) had higher overall HOME scores at 18 months as compared with at 12 months, 17% remained the same and 42% had lower scores.

Comparison of HOME Assessments at 6 and 18 Months

There were 88 families that had both a 6 and 18-month HOME assessment. In comparing the 6 and 18-month HOME scores, it was found that the overall HOME score improved by 2.5 points (a 7% increase), on average. This change in HOME scores is statistically significant.[24] Scores on four of the six dimensions (i.e., responsivity,[25] organization,[26] learning materials[27] and variety[28]) of the HOME assessment scale showed statistically significant improvements. The biggest improvement was in the availability of learning materials for the child, which improved by 1.2 points (17%) between the point when the child was 6 and 18 months old. There was an insignificant deterioration in the acceptance dimension (i.e., by 0.3 points) between 6 and 18 months. Most (59 or 67%) families had higher overall HOME scores at 18 months as compared with at 6 months, 6% remained the same and 27% had lower scores.

Table 13
Average HOME Scores Among POCAN Cases that Have Both a 6 and 18-Month Assessment

HOME Score Components	Range of Possible Scores	Average 6 Month HOME Scores	Average 18 Month HOME Scores
Responsivity	0-11	9.1	9.8
Acceptance	0-8	6.1	5.8
Organization	0-6	4.9	5.2
Learning Materials	0-9	6.9	8.1
Involvement	0-6	4.5	4.6
Variety	0-5	3.2	3.7
Total HOME Score	0-45	34.7	37.2

In summary, the analysis of HOME assessments found statistically significant improvements in family functioning and positive parenting practices. The greatest improvements were made between 6 and 12 months. Statistically significant improvements in total HOME scores were found between the assessments done at 6 and 12 months and also between the assessments done at 6 and 18 months. Positive parenting practices relating to the availability of learning materials for the child showed the greatest improvements between 6 and 18 months, improving by 1.2 points or 17%.

[24] P=.0001 and T-Value=5.29.
[25] P=.0002 and T-Value=3.88
[26] P=.0319 and T-Value=2.18
[27] P=.0001 and T-Value=6.10
[28] P=.0005 and T-Value=3.64

Caveats in the Interpretation of Changes in HOME Scores. POCAN staff have noted that the HOME assessments fail to measure the total impact that they have had on improvements in family functioning and parenting practices because the first measure was generally taken after they had worked with the family for several months. The Projects indicate that they begin to provide training to parents to build positive parenting practices and improve family functioning upon enrollment and continue to provide these services throughout the Program. Since most families were enrolled shortly after the birth of the child,[29] POCAN staff had already worked with the family for up to 6 months prior to the first HOME assessment. They believe that a HOME assessment upon enrollment would have provided better baseline data to use to measure overall improvements in family functioning and parenting practices.

In the original study that developed the HOME instrument, it was found that HOME scores increased over time and that the biggest increases were between 6 and 12 months of age.[30] Thus while the statistically significant increases in HOME scores over time for POCAN families are encouraging, they may reflect changes that could have occurred naturally over time, without the services of the POCAN program. Because this evaluation did not include a comparison or control group, we cannot determine how much of the change in POCAN families' HOME scores over time are due to natural changes that would have occurred without the benefit of the POCAN program services. The absence of a comparison or control group also makes it difficult to determine the practical significance of the increase in POCAN families' HOME scores over time. The 2-point gain shown by POCAN families from 6 to 12 months was similar to the difference between the scores of families with 6-month old and 12-month children in the standardization sample for the HOME. However standardization sample scores were collected nearly 30 years ago (1974), and families in the standardization sample differ from the POCAN families in a number of important respects. For example, 71% of the HOME standardization sample families were two-parent families, and the percent of standardization sample children that were African American (66%) was much greater than among POCAN program families.[31] Thus, even though the HOME may be a very useful instrument for structuring family observations, it may not be appropriate to use the scores of families in the HOME standardization sample as a basis for comparison to evaluate the impact of the POCAN program.

As an alternative, to interpret the practical significance of the increase in POCAN families' HOME scores over time, we calculated the effect size for the 6 versus 12, 12 versus 18, and 6 versus 18-month comparisons. The effect size presents pre-post gain scores in standard deviation units. It is used to judge the practical significance of observed changes over time or of differences between program participants' and comparison groups' scores. Effect sizes calculated for

[29] The median age of children at POCAN enrollment was 1.5 months and 91% of the cases were enrolled before the child had reached 6 months.

[30] Bradley, Robert and Caldwell, Bettye (1984). Administration Manuel (Revised Edition) Home Observation for Measurement of the Environment. The HOME study established the following norms for HOME scores: 28.49 at 6 months, 30.85 at 12 months and 31.69 at 24 months.

[31] 2% of the POCAN mothers were married at intake and 6% of POCAN children were African American. Standardization sample scores for the HOME instrument which was used for the POCAN study were developed based on testing a population of 174, mostly non-welfare (66%) families in Arkansas.

POCAN families' HOME scores were: 0.42 for 6 versus 12 months, 0.0045 for 12 versus 18 months, and 0.56 for 6 versus 18 months.[32] In comparison, Lipsey classifies effect sizes from 0 to .32 as "small," from .33 to .55 as "medium," and from .55 to 1.20 as "large." [33]

Thus the effect sizes calculated for the POCAN program participants' scores suggest that in addition to being statistically significant, the gains shown by POCAN families from 6 to 12 months and from 6 to 18 months on the HOME are of practical significance.

POCAN Caseload Retention. The statutes require that the study report on the number of families who remained in the home visitation program for the time recommended in the case plan. Such criteria for program participation were rarely specified in the case plan. The POCAN program is designed to serve clients through the child's third birthday in order to provide long-term support and on-going parenting education. If the risk of child abuse/neglect continues at this point, the POCAN Projects are allowed to continue to serve the case. DPH set up a risk evaluation process that is used to measure risk at age 3.[34] As an alternative to reporting on program retention relative to non-existent case plan duration goals, the study assessed the number of cases that were still active at the end of the three-year follow-up period and that were still active through the child's third birthday. Among the cases that were open at the end of follow-up, the child's age on June 30, 2002 was analyzed. Among those cases that had closed, the age of children at closure was analyzed.

At the end of the three year follow-up period, 38% (89 cases) of the POCAN cohort was still active. Forty cases (17%) closed during the first year of follow-up. About one-third (32% or 76 cases) of the cases closed during the second year of follow-up, leaving 120 open cases (i.e., 51% of the original cohort). Thirty-one cases (13%) closed during the third year of follow-up.

During the three-year study period, Portage County had the lowest closure rate at 25% and Fond du Lac County had the highest closure rate at 80%. It should be noted that the POCAN Projects

[32] To calculate the effect size, the difference between each family's pre and post HOME score was calculated. The average difference score was then divided by the standard deviation of the difference scores. See Jacob Cohen, Statistical Power Analysis for the Behavioral Sciences, Second Edition, Lawrence Erlbaum Associates Publishers, 1988, Chapter 2, " The T Test for Means," Case 4. page 72.

[33] Mark W. Lipsey, Design Sensitivity, Statistical Power for Experimental Research Sage Publications, 1990, page 56. Lipsey's classification is based on an analysis of effect sizes reported in over 100 studies in mental health and education. There are a number of other guidelines for interpreting effect sizes. McNamara notes that most educational researchers agree that an effect size of 0.50 is considered a conventional measure of practical significance but that there are no hard and fast rules for classifying effect sizes. He notes that some have suggested that an effect size of 0.33 is a good indicator of practical significance in action research projects undertaken by classroom teachers. He also reports that the National Institute of Education's Joint Dissemination Review Panel observed than an effect size of 0.33 or even one as small as 0.25 is often considered to be educationally significant. James F. McNamara, Surveys and Experiments in Education Research, Technomic Publishing Co. 1994, page 132.

[34] Among the 48 children from the cohort that were still active on 12/31/02 and where the child had turned age 3, 37 (77%) were determined to be of high enough risk to continue to be eligible for POCAN.

continued to enroll new clients as cases were closed. However, these new cases were not included in the study cohort because of the limited follow-up that would be possible.[35]

Table 14
POCAN Enrollments in FY 2000 and Caseload Retention Through 6/30/2002

County	Cases Open at end of 3 Year Study Period	Cases Closed During Three Year Study Period		
		Year #1 Closures	Year #2 Closures	Year #3 Closures
Brown (N=53)	24 (45%)	6 (11%)	17 (32%)	6 (11%)
Door (N=9)	3 (33%)	1 (11%)	4 (44%)	1 (11%)
Fond du Lac (N=25)	5 (20%)	9 (36%)	10 (40%)	1 (4%)
Manitowoc (N=30)	12 (40%)	7 (23%)	8 (27%)	3 (10%)
Marathon (N=43)	11 (26%)	7 (16%)	16 (37%)	9 (21%)
Portage (N=16)	12 (75%)	0	1 (6%)	3 (19%)
Vernon (N=11)	5 (45%)	1 (9%)	4 (36%)	1 (9%)
Waukesha (N=32)	9 (28%)	6 (19%)	13 (41%)	4 (13%)
Waupaca (N=17)	8 (47%)	3 (18%)	3 (18%)	3 (18%)
Totals (N=236)	89 (38%)	40 (17%)	76 (32%)	31 (13%)

Other studies have found that client attrition is a chronic problem with home visiting child abuse prevention programs.[36] For example, a study of the Oregon Healthy Start Program[37] found that 45% of clients closed within one year of enrollment, and a study of the Hawaii Healthy Start Program[38] found that 51% of clients closed within one year of enrollment. Among families in the POCAN study cohort, the closure rate within the same standardized one-year follow-up period was 36%.

Age of Children as of June 30, 2002 Among Active Cases. Among the active cases, six of the children had reached the age of 3, and 83 children were under age 3 as of June 30, 2002. The younger children from the active cases turned 3 or will turn 3 between July 4, 2002 and June 30, 2003. It is expected that the POCAN Projects will continue to serve these 83 cases until the child reaches age age 3, or longer if risk continues.

Age of Child at POCAN Closure. Among those cases that were closed prior to the end of the three-year follow-up period, children ranged from 2 to 40 months of age at closure. On average,

[35] The POCAN home visitation annual budgeted caseload slots in the cohort counties were: CY 1999 – 146; CY 2000 – 277; CY 2001 – 276; and 2002 – 293. Since inception, the number of different families served by the POCAN cohort counties each year were: CY 1999 – 132; CY 2000 – 342; CY 2001 – 352; and 2002 – 377.
[36] McGuigan, William, Katzev, Aphra and Pratt, Clara. Multi-Level Determinants of Retention in a Home-Visiting Child Abuse Prevention Program. *Child Abuse and Neglect 27*, April 2003, 363-380.
[37] IBID.
[38] Duggan, Anne, McFarlane, Elizabeth, Windham, Amy, Rhode, Charles, Salkever, David, Fuddy, Loretta, Rosenberg, Leon, Buchbinder, Sharon and Sia, Calvin. Evaluation of Hawaii's Healthy Start Program. The Future of Children Home Visiting Recent Program Evaluations, Vol. 9 No.1 – Spring/Summer 1999.

the child in closed cases was 14 months of age at closure. On average, the closed cases were the youngest in Vernon County (8 months) and the oldest in Portage County (21 months).

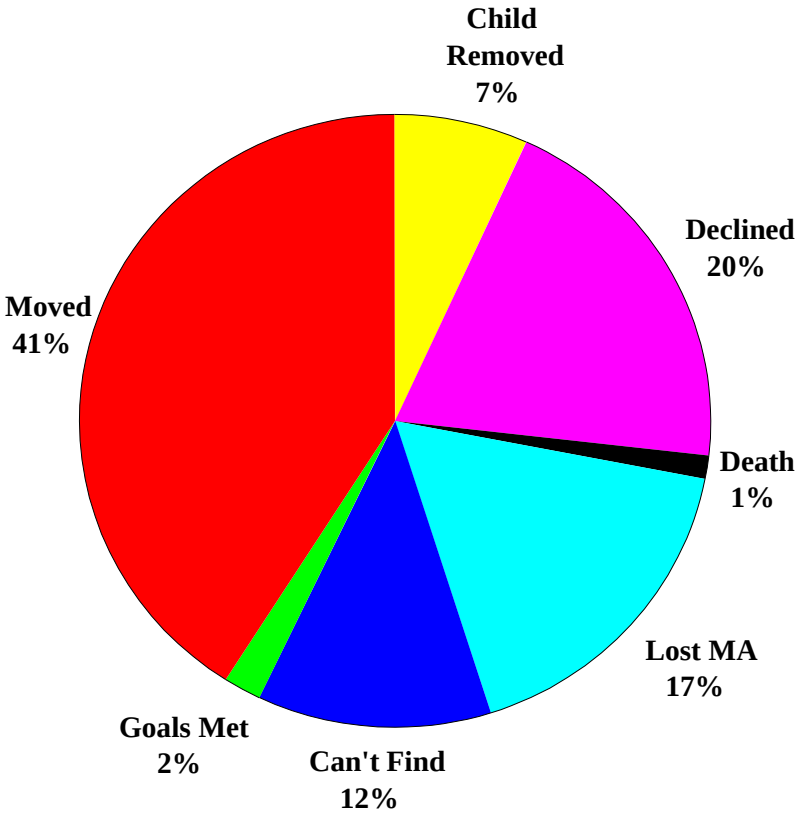
In all but one of the closed cases, the child was under age 3 at closure. Among closed cases, 41% (61 cases) were under 12 months of age, 45% (66 cases) were age 1 to 2 years of age and 13% (19 cases) were 2 to 3 years of age at closure.

Table 15
Age of Children at Closure

Project	Average Age of Children at POCAN Closure	Range of Ages at POCAN Closure
Brown	15 months	3 to 35 months
Door	12 months	7 to 22 months
Fond du Lac	17 months	7 to 35 months
Manitowoc	11 months	2 to 22 months
Marathon	15 months	3 to 31 months
Portage	21 months	18 to 25 months
Vernon	8 months	3 to 13 months
Waukesha	13 months	3 to 29 months
Waupaca	18 months	10 to 40 months
All Projects	14 months	2 to 40 months

Closure Reasons. The most common reason for closure was that the client moved out of the county (61 cases). County residency is a program requirement. POCAN is a voluntary program and 30 clients declined services following enrollment. MA eligibility is another program requirement. Twenty-four cases were closed because the mother lost MA eligibility and consequently, the family would lose their MA and POCAN eligibility within nine months. Most (20 of 24) of these families were transferred to an alternative county home visitation program that had different funding sources The POCAN Projects lost contact with 18 clients following enrollment and the cases were eventually closed after several months due to being unlocatable. These cases may have moved within or outside the county.

Figure 6
Reasons for POCAN Closure



Overall reasons for closure, including the number of families closed for each reason were:

- Client Moved – 61 cases (41%)
- Client Declined Services – 30 cases (20%)
- Client lost MA Eligibility 24 cases (17%)
- Cannot Locate Client – 18 cases (12%)
- Child Removed from Home – 10 cases (7%)
- Client Goals Met – 3 cases (2%)
- Child Died – 1 case (1%)[39]

Closure due to moving dramatically affected the cohort's program retention rate. Poor people tend to move quite frequently. Moving may be a positive outcome because it may occur for reasons such as the pursuit of economic opportunities and/or family reintegration. While 62% of all cases from the cohort closed by the end of the follow-up period, if the movers are excluded in computing the POCAN closure rate, the closure rate would be 36%.

[39] Child's cause of death was Sudden Infant Death Syndrome (SIDS).

Characteristics of Clients that Closed Prior to June 30, 2002. We ran statistical tests to determine if there was a relationship between various demographic characteristics and Program retention. The demographic characteristics that were analyzed included:

- Age at POCAN enrollment (mother and child)
- Risk Level at POCAN Intake
- Marital status of the mother at POCAN enrollment
- Race and ethnicity of the mother
- Educational status of the mother at POCAN enrollment and at the end of follow-up
- Employment status of the mother at POCAN enrollment and at the end of follow-up

The only demographic characteristic that was found to have a statistically significant relationship to program retention was the age of the child at POCAN enrollment. In those cases where the child was over 6 months of age at enrollment, the family was significantly more likely to close prior to the end of the follow-up period.[40] Almost all (21 of 22 or 95%) of these families closed prior to the end of the follow-up period. In comparison, among the cases that were enrolled within three months of the child's birth, 41% were still active and among the cases that enrolled when the child was 3 to 6 months of age, 43% were still active at the end of the follow-up period. These findings are consistent with the POCAN Home Visitation Critical Element that recommends that POCAN services be initiated in close proximity[41] to the birth of the child to maximize engagement into the Program. At this point, the mother is more likely to be accepting of parenting information and this is considered to be the ideal time to form bonds necessary to establish a supportive relationship with families.

Older mothers (over age 21 at intake) were slightly more likely to remain on POCAN than were younger mothers. Among the mothers who were over age 21, 39% were still active on June 30, 2002. In comparison, 36% of the younger mothers were still active at the end of the follow-up period.

Highest risk families were somewhat more likely to close prior to the end of follow-up. Those families that had risk scores in the top-third were classified as "highest risk" for this analysis.[42] Among the highest risk families, 69% closed prior to June 30, 2002. In comparison, 58% of the lower risk families closed prior to the end of follow-up.

The mothers that were married at intake were more likely to remain active on POCAN; however, their numbers were too small to do valid statistical analysis on this characteristic. Among the married mothers, 80% (4 cases) were still active at the end of the follow-up. In comparison, 65% of the single mothers closed prior to June 30, 2002.

Minorities were more likely to remain active than were whites. Among the cases where the mother was of a racial minority, 47% were still active at the end of the follow-up. In comparison,

[40] P=.01.
[41] Critical Element #1 states that the home visitation program "initiate services during the prenatal period or at birth".
[42] Families with a PNCC score over 127 or a Family Questionnaire score over 297 were classified as "highest risk."

35% of the white mothers were still active on June 30, 2002. Hispanic mothers had similar program retention rates as did non-Hispanic mothers (i.e., 35% and 37%, respectively).

Mothers who were employed at intake were slightly more likely to remain active through June 30, 2002 than were mothers who were unemployed at intake (i.e., 39% and 35%, respectively). Mothers who were employed at the end of follow-up were also slightly more likely to remain active than were mothers who were unemployed (i.e., 40% and 35%, respectively).

Mothers who had lower education levels at intake were slightly more likely to close prior to June 30, 2002. Among the mothers who had not completed high school, 65% closed; among the mothers with a GED, 80% closed; among the mothers with a high school diploma, 60% closed; and among the mothers with some post secondary education, 47% closed prior to June 30, 2002. Mothers who were in school at the end of follow-up were more likely to close. Among the mothers who were in school at the end of follow-up, 74% closed; and among the non-students, 60% closed prior to June 30, 2002.

Time in POCAN Program. Among all cases in the cohort, time in the program averaged 544 days (18 months). Program participation time ranged from 22 days to nearly 3 years (i.e., 1,080 days). Among the cases that were still active at the end of the follow-up period, program time as of June 30, 2002 averaged 879 days and ranged from 730 to 1,080 days. Among the cases that were closed prior to June 30, 2002, program time averaged 341 days and ranged from 22 to 852 days.

Other Outcomes

Use of Primary Care Physicians

In planning this evaluation, the POCAN Projects and DPH asserted the importance of access to regular medical care for children by establishing a medical home. As a measure of this, Projects suggested that the evaluation track whether clients had primary care physicians. Most participants had a primary care physician at some point during POCAN. At the close of follow-up, 98% of the cohort had a primary care physician. Most (90%) of the cohort had a primary care physician continuously during their participation in POCAN, and 8% did not have a primary care physician at intake, but had one at the close of follow-up. There were four children that had a primary care physician at intake, but not at the close of follow-up. Only one child never had a primary care physician while on POCAN. This family minimally participated in POCAN. POCAN staff only had one direct contact with the family, and they moved out of the county two months after enrollment.

POCAN Critical Element #7 specifies that all families should be linked to a health care provider. The fact that the vast majority of clients had a primary care physician indicates that POCAN staff have effectively implemented this guiding principle.

Second Pregnancies

One of the goals of the POCAN program is to encourage participants to delay second births until the first child has reached at least 2 years of age. One important resource for supporting this goal is the family planning services available to POCAN clients. Projects reported that 149 clients (63%) were referred to family planning services during the first year of the program.
The study tracked subsequent births that occurred during the follow-up period and computed the interval between the birth of the first and second children. Forty-six (19%) of the mothers from the cohort became pregnant prior to the end of follow-up. In just over half (54%) of these pregnancies, the second child was due or delivered within two years of the first child. Therefore, 11% of the mothers in the cohort were due or delivered within two years of the birth of their first child. On average, there was an interval of 678 days (1 year, 10 months) between the birth of the first child and the due date/delivery of the second child. The interval between the birth of the first child and the due date/delivery of the second child ranged from 289 days (9.5 months) to 1,253 days (41.2 months).

There were second births among 35 clients that were still active at the end of the three-year follow-up period. Seventeen (49%) of these births were within two years of the birth of the first child. There were second pregnancies among 11 clients that were closed prior to the end of the three-year follow-up period. Eight (73%) of these births were within two years of the birth of the first child. Since most closures were within two years of POCAN enrollment, data on second pregnancies among closed cases is incomplete.

Changes in Employment Status

The study collected data regarding the employment status of the mothers upon closure or the end of the 3-year follow-up period. This data was compared with their employment status at intake. Since employment data was available on so few of the fathers/parenting partners at intake and since many of these fathers/parenting partners terminated their relationship with the mother prior to the end of follow-up, data on the employment status of the fathers/parenting partners was not tracked.

Most (59%) of the mothers in the cohort were unemployed at intake. About one-fifth (21%) were employed part-time and 20% were employed full-time at intake. Most of the mothers were employed at some point while on POCAN. About one-fourth (27%) were continuously employed while on POCAN. About half were employed at some point, but not continuously employed while on POCAN. About one-fifth (21%) were unemployed the entire time that they were on POCAN.

At the close of follow-up, 44% of the mothers were unemployed, 34% were employed full-time and 22% were employed part-time. Their employment status at the close of follow-up was compared with that at intake and it was found that in most cases (62%), there was no change in the mother's employment status. Over a third (36%) of the mothers were unemployed at both intake and at the close of follow-up, and 26% were employed at the same level at intake and at the close of follow-up.

Several mothers (28%) had increased their level of employment. In most (54) of these cases, the mother had been unemployed at intake and was employed full-time at the close of follow-up. In the remainder of these cases, the mother was employed part-time at intake and was employed full-time at the close of follow-up. These positive employment outcomes may have been influenced by the availability of POCAN services, but are not necessarily the direct result of the availability of POCAN services. Other services, such as W2 services, likely had a more direct and greater impact on improvements in employment status.

There were a few cases (22 or 10% of the cohort with data) where the mother's employment level had decreased during POCAN. In most of these cases (15) the mother was employed part-time at intake and unemployed at the close of follow-up. Of the remaining cases with decreased employment, four went from full-time employment at intake to part-time employment, and three went from full-time employment at intake to unemployment at the close of follow-up.

Changes in Educational Status

The study collected data regarding educational program participation and the educational status of the mothers upon closure or the end of the 3-year follow-up period. This data was compared with their educational status at intake. Since most data on the educational level of the fathers/parenting partners was missing at intake, the educational status of the fathers/parenting partners was not tracked.

Most of the mothers in the cohort had minimal education at intake. About one-third (34%) had graduated from high school and 9% had attained a GED. Only a few cases (15) had any education beyond high school. Several of the mothers were in school while on POCAN and some improved their educational status. At the end of follow-up, 35 of the mothers were in some type of educational program. Most were in high school (12) or studying for their GED (10). Six were in a two-year technical college program and four were working on a four-year college degree. Three were studying in a continuing or other type of educational program.

Most (84%) of the mothers had made no change in their educational attainments while in the POCAN program. There were 34 cases where the mother had improved her educational status by initiating or completing an educational program while in the program. Among the cases that made educational progress, 19 attained their high school diploma/GED, six completed high school and went on to college, seven who already had their high school diploma at intake initiated a college educational program, and two who had some college at intake completed their degree. These positive educational outcomes may have been influenced by the availability of POCAN services, but are not necessarily the direct result of the availability of POCAN services. Other services, such as W2 services, likely had a more direct and greater impact on improvements in educational status.

Program Operations

Client Contacts

Direct Client Contacts. At the time of entry into the program, clients are expected to require visits on a weekly, or more frequent, basis. The frequency of client visits is then expected to decrease as families continue in the POCAN program and increase their parenting skills and knowledge and ability to access community services.

Following enrollment, among all cases, there were an average of 73 direct client contacts. Direct client contacts ranged from 1 to 310 per case. The average time per direct client contact was 47 minutes. POCAN staff spent an average of 3,435 minutes (57.3 hours) in direct client contact time per case.

Among cases that were still active at the end of the follow-up period, the average number of direct contacts was 117. The range of direct contacts was 17 to 310 per case. The average time spent providing case management and other direct services to these cases was 5,476 minutes (91.3 hours) through June 30, 2002. The average time per direct contact was 47 minutes.

Among cases that had closed prior to the end of the follow-up period, the average number of direct contacts was 45. The range of direct contacts was 1 to 163. The average time spent providing case management and other direct services to these cases was 2,188 minutes (36.4 hours) prior to closure. The average time per direct contact was 48 minutes, which was quite similar to that spent on open cases.

Collateral Contacts. Collateral contacts are defined as contacts with other service providers or community resources made on behalf of a case. Among all cases, the average number of collateral contacts was 28 per case and the range was 0 to 187 collateral contacts per case. The average time per collateral client contact was 16 minutes. POCAN staff spent an average of 464 minutes (7.7 hours) in collateral contact time per case.

Among cases that were still active at the end of the follow-up period, the average number of collateral contacts was 39. The range was 1 to 187 collateral contacts per case. The average time spent on collateral contacts on behalf of the active cases was 623 minutes (10.4 hours) through June 30, 2002. The average time per collateral contact was 16 minutes.

Among cases that had closed prior to the end of the follow-up period, the average number of collateral contacts was 22. The range was 0 to 180 collateral contacts per case. The average time spent on collateral contacts on behalf of the these cases was 367 minutes (6.1 hours) prior to closure. The average time per collateral contact was 17 minutes, which was quite similar to that spent on open cases.

Client Contacts Among all Enrollees, by Project. There was considerable variation in the time spent on client contacts when the analysis broke out data by individual POCAN project. On average, the Door County POCAN Project provided the highest number of direct client contacts (139) and the Portage County POCAN Project spent the most time on direct client contacts (6,379 minutes). The Waukesha County POCAN Project provided the highest number of collateral contacts (66) and also spent the most time, on average, on collateral contacts (1,202 minutes). On average, the Marathon County POCAN Project provided the lowest number of direct client contacts (36) and the Waupaca County POCAN Project spent the least time, on average, on direct client contacts (2,333 minutes). The Manitowoc and Marathon County POCAN Projects provided the lowest number of collateral contacts (8) and the Manitowoc County POCAN Project spent the least time, on average, on collateral contacts (155 minutes).

Table 16
Means on Client Contacts per Case, By Project Among all Clients

Project	Average Number Of Direct Client Contacts	Average Total Time on Direct Client Contacts	Average Number of Collateral Contacts	Average Total Time on Collateral Contacts
Brown	98	3,647 Minutes	23	275 Minutes
Door	139	4,591 Minutes	33	300 Minutes
Fond du Lac	54	2,935 Minutes	28	327 Minutes
Manitowoc	66	3,448 Minutes	8	155 Minutes
Marathon	36	2,399 Minutes	8	175 Minutes
Portage	126	6,379 Minutes	36	895 Minutes
Vernon	66	3,628 Minutes	50	927 Minutes
Waukesha	63	3,486 Minutes	66	1,202 Minutes
Waupaca	61	2,333 Minutes	34	464 Minutes
Totals	73	3,435 Minutes	28	464 Minutes

Client Contacts Among Clients Still Active on June 30, 2002, by Project. The evaluation also analyzed client contacts controlling for whether the client was still active at the end of the three-year follow-up period. Since some Projects had much higher closure rates, particularly during the earlier years of the follow-up period, it was believed that this approach allowed for more reasonable inter-Project comparisons of the intensity of services than a simple analysis of overall contact levels among all clients in the cohort.

There was considerable variation in the time spent on client contacts when the analysis broke out data by individual POCAN project. On average, the Door County POCAN Project provided the highest number of direct client contacts (227) and also spent the most time on direct client contacts (7,263 minutes). The Waukesha County POCAN Project provided the highest number of collateral contacts (96) and also spent the most time, on average, on collateral client contacts (1,613 minutes). On average, the Marathon County POCAN Project provided the lowest number of direct client contacts (56) and the Waupaca County POCAN Project spent the least time, on average, on direct client contacts (3,385 minutes). The Manitowoc and Marathon County POCAN Projects provided the lowest number of collateral contacts (11) and the Marathon County POCAN Project spent the least time, on average, on collateral contacts (180 minutes).

Table 17
Means on Client Contacts per Case, By Project
Among Clients That Were Still Active at the End of the Three Year Follow-up Period

Project	Average Number of Direct Client Contacts	Average Total Time on Direct Client Contacts	Average Number of Collateral Contacts	Average Total Time on Collateral Contacts
Brown	149	5,789 Minutes	31	391 Minutes
Door	227	7,263 Minutes	48	425 Minutes
Fond du Lac	118	6,310 Minutes	43	412 Minutes
Manitowoc	97	5,016 Minutes	11	221 Minutes
Marathon	56	4,245 Minutes	11	180 Minutes
Portage	138	6,668 Minutes	37	885 Minutes
Vernon	117	6,363 Minutes	86	1,604 Minutes
Waukesha	104	5,511 Minutes	96	1,613 Minutes
Waupaca	83	3,385 Minutes	43	589 Minutes
Totals	117	5,476 Minutes	39	623 Minutes

POCAN Referrals to Programs for Services and Treatment

Case management is an integral component of the POCAN program. The risk assessment that is done as part of POCAN eligibility determination identifies many social and family problems that could be impacted through the provision of treatment and other services. Some of the risk factors that are considered in evaluating cases for POCAN enrollment are employment status, education level, parenting skills, substance abuse, mental health problems and domestic violence. The provision of appropriate intervention, treatment and services can help alleviate family problems and stress, and prevent child abuse and neglect.

The evaluation collected data on referrals that POCAN staff made to various types of programs and services. These included specific major DHFS programs such as the Birth to 3 Program and the Women, Infants and Children Program (WIC) and general programs/services such as public health programs, basic needs programs and parenting programs. The evaluation also collected data as to whether the client followed through on the referral and whether they actually received services.

Referrals to the Birth to 3 Program. The Birth to 3 Program is an early intervention program, which serves infants and toddlers with developmental delays and disabilities. As of December 1, 2001, the Birth to 3 program was serving 5,212 children, 2.6% of the Wisconsin population between ages 0 and 3 years.

Most (87%) children from the cohort were screened to assess whether there were developmental delays. There were 26 POCAN children who were identified as having developmental delays. This represents 13% of the children who were screened. Most (25 of 26 or 11% of the cohort) of these children were referred to the Birth to 3 Program. Of these, twenty children (8% of the cohort) received Birth to 3 services.

Referrals to Nutrition Support Programs. There were 96 families that were referred to a nutrition support program by POCAN staff. Most (90%) of the cases that were referred followed through on the referral and 88% of these referrals received nutrition support program services as a result of the referral.

The major nutrition support program that is run by DHFS is the Women, Infants and Children Program (WIC). WIC provides food and information on nutrition to low-income women who are pregnant and nursing and to infants and children under five. To be eligible for WIC, participants need to have incomes under 185% of the federal poverty level and be at nutritional risk. The income limit for the WIC program is the same as that of the Medicaid Healthy Start program. As all POCAN clients are Medicaid eligible, it is likely that the entire POCAN population is eligible for WIC benefits. During the first year of POCAN, 223 cases (94% of the cohort families) were reported as having been enrolled in the WIC program. Some of these cases were already receiving WIC services at POCAN intake.

Referrals to Health Care Providers. All POCAN clients are eligible for Medical Assistance so they have access to a comprehensive range of health care services at minimal or no direct cost. Young children require frequent medical care to insure that preventive services are provided and necessary treatment is received. POCAN staff referred 72 clients (31% of the cohort) to a health care provider or physician. Most (82%) clients followed through on the referral and POCAN staff reported that 81% received services from the health care provider as a result of the referral.

Referrals to Public Health Services Programs. POCAN staff referred 60 clients (25% of the cohort) to a public health program. Most (82%) clients followed through on the referral and POCAN staff reported that 80% received services from a public health services program as a result of the referral.

Referrals to Parenting Programs. Enhancing parenting skills is a key component of POCAN and critical to preventing child abuse and neglect. POCAN staff referred 67 clients (28% of the cohort) to a parenting program. Many (66%) clients followed through on the referral and POCAN staff reported that 60% received services from a parenting program as a result of the referral.

Referrals to Basic Needs Programs. POCAN families are very low income and are at or below the poverty level. Many can benefit from services that meet basic needs relating to food, clothing and shelter. POCAN staff referred 118 clients (50% of the cohort) to a basic needs program, generally relating to assistance with housing. Most (82%) clients followed through on the referral and POCAN staff reported that 80% received services from a basic needs program as a result of the referral.

Referrals to Employment and/or Educational Programs. At intake, most POCAN clients had low education levels and were unemployed. POCAN staff referred 90 clients (38% of the cohort) to an employment or adult education program. Many (60%) clients followed through on the referral, and POCAN staff reported that 54% received services from an employment or adult education program as a result of the referral.

Referrals to Transportation Programs. Many low-income persons lack access to transportation and this can impact their ability to receive needed services and engage in education and/or employment. Many of the POCAN projects are in rural counties that lack public transportation. POCAN staff referred 46 clients (19% of the cohort) to a transportation program. Most (76%) clients followed through on the referral and POCAN staff reported that 70% received services from a transportation program as a result of the referral.

Referrals to Violence Programs. Family violence is a risk factor that is used to determine eligibility for POCAN services, and it is likely that many children are at risk of abuse and neglect due to family violence. POCAN staff referred 34 clients (14% of the cohort) to a violence program. Less than half (47%) of these clients followed through on the referral, and POCAN staff reported that only 41% received services from a violence program as a result of the referral.

Referrals to Alcohol, Tobacco and/or Other Drug Abuse Programs. POCAN staff referred 13 clients (6% of the cohort) to alcohol, tobacco and/or other drug abuse programs. About half (54%) of these clients followed through on the referral, and POCAN staff reported that 39% received services from an alcohol, tobacco and/or other drug abuse program as a result of the referral.

Referrals to Mental Health Intervention Programs. POCAN staff referred 61 clients (26% of the cohort) to mental health treatment programs. About half (56%) of these clients followed through on the referral, and POCAN staff reported that 51% received services from a mental health treatment program as a result of the referral.

Types of Program Referrals By Project. There was considerable variation among Projects in the proportion of the caseload that was referred to various types of programs. Some of this variation in referrals could be due to variations in the extent and nature of problems presented by the caseload, and some of the variation could be due to limitations in the local availability of specialized programs.

Table 18
Types of Program Referrals By Project

	% of POCAN Clients Referred to Various Types of Programs and Services										
Project	Birth to 3 Program	Health Care Provider	Public Health Services Program	Nutrition Support Program*	Parenting Support Program	Basic Needs Program	Employment and/or Education Program	Transportation Assistance	Violence Provider	AODA Program	Mental Health Program
Brown	11%	17%	6%	17%	6%	28%	15%	8%	9%	2%	17%
Door	0	67%	100%	78%	0	67%	78%	67%	44%	33%	56%
Fond du Lac	24%	48%	36%	48%	52%	8%	44%	12%	16%	0	52%
Manitowoc	13%	17%	13%	47%	50%	47%	33%	17%	17%	0	13%
Marathon	0	19%	12%	9%	7%	30%	28%	9%	9%	5%	21%
Portage	13%	56%	38%	44%	13%	94%	44%	44%	25%	19%	6%
Vernon	9%	9%	46%	73%	82%	82%	64%	27%	0	0	0
Waukesha	19%	44%	28%	81%	50%	88%	72%	34%	19%	13%	44%
Waupaca	0	47%	59%	53%	35%	94%	29%	18%	12%	0	35%
Totals	11%	31%	25%	41%	28%	50%	38%	19%	14%	6%	26%

*Includes WIC.

Targeted Case Management Funding

Targeted Case Management Requirements. The POCAN Counties are eligible for reimbursement from Medicaid for targeted case management services (TCM) provided to POCAN clients. The POCAN grant requires that the Counties make efforts to capture TCM funds. Medicaid may be billed for three distinct types of targeted case management services. These are assessments, case planning and ongoing monitoring/service coordination. The Projects may bill for up to 2 assessments and case plans per year. They must have already billed Medicaid for assessment and case planning services to be eligible to bill for ongoing monitoring/service coordination. The Projects are eligible to be reimbursed the federal share of Medicaid, which is about 60% of total costs. The county is responsible for the approximate 40% Medicaid match.

There are complex eligibility criteria and several restrictions on TCM. The client must be MA eligible and in a designated target group. POCAN clients are eligible because they meet PNCC eligibility criteria and qualify for the TCM target group "families of children at risk of physical, mental or emotional dysfunction." TCM may only be drawn from one program, so clients who are receiving services from multiple programs, such as Birth to 3, may already be capturing funding via these alternative programs and be ineligible to also receive TCM reimbursement for POCAN services. TCM billings must be made by a county entity, even if the POCAN program is subcontracted to a private vendor, such as is the case in Brown, Manitowoc and Marathon Counties. The capturing of TCM revenues does not result in an increase in the POCAN Project's allocation. The primary beneficiary of TCM revenues is the county, which can use these funds to pay for POCAN administrative costs or to use as match money for POCAN flexible funding services.

Total Billings and Reimbursements. The POCAN Projects received federal Medicaid reimbursement totaling $111,944 for TCM provided to POCAN clients from the cohort during the three-year study period of FY 2000 through FY 2003. This represents 44% of the total billings for TCM services.[43] The amount of TCM funds captured per client ranged from $11.40 to $3,184.33. Ongoing monitoring and services coordination was the major type of service for which funding was received, accounting for 81% of all TCM reimbursement.

[43] Counties are expected to bill MA at the higher of their actual TCM service cost or at the established contracted MA TCM rate (e.g., $43.27 per hour in CY 2003). The Counties are only eligible to receive the federal pass through share of MA. TCM is reimbursed at up to 60% of the approved federal rate. For FFY 2003, the maximum reimbursement that can be captured from the federal government for TCM services is $25.28/hour.

Table 19
Targeted Case Management Service Billings and Payments for POCAN Services Provided to Clients in the Cohort, July 1999 through June 2002

Targeted Case Management Service	Total Amount Billed	Total Amount Paid
Assessment	$29,200.91	$12,410.13
Planning	$22,055.90	$9,395.39
Ongoing Monitoring and Service Coordination	$200,846.43	$90,138.95
Totals	$252,103.24	$111,944.47

It should be reiterated that this study only tracked and reported data on TCM revenues among the 236 families from the study cohort during the 3-year study period. The Projects also received federal Medicaid reimbursement for TCM services provided to many families that were enrolled following the selection of the cohort, and they also continue to bill for services provided to some active families from the cohort. Data on the extent of these additional TCM billings was not collected by this evaluation.

TCM Reimbursements by Project. Some Projects collected significant revenues for providing TCM services to the vast majority of the families in the cohort, while others made only minimal attempts to tap this federal funding source. Some Counties have established accounting units that routinely bill MA for TCM for clients served by various programs, including POCAN. Some Projects have indicated that they consider the TCM billing process to be cumbersome or that the administrative costs of these billings exceed the benefits. In some cases, the county keeps most of the TCM revenues to cover administrative costs and relatively little of the TCM reimbursement is made available for direct POCAN services. In such cases, the POCAN Projects do not consider the TCM billing process to be a cost-effective use of POCAN staff time. Some Projects are confused as to criteria that must be met to be eligible to bill for TCM services and are fearful of audit exceptions, and consequently are hesitant to submit billings. Some Projects were lacking valid MA identification numbers on many clients in the cohort for several years and as a result, were unable to bill MA for TCM services.

Table 20
Targeted Case Management (TCM) Service Reimbursements by Project, FY 2000 to FY 2002

Project	Total TCM Assessment Revenues	Total TCM Planning Revenues	Total TCM Ongoing Monitoring & Service Coordination Revenues	Total TCM Revenues Captured	Average TCM Reimbursement Per Capita (All Cases in Cohort)[44]	Average TCM Reimbursement Per Capita (Cases with Revenue)
Brown	$2,578.90	$1,315.11	$19,590.02	$23,484.03	$443.09 (N=53)	$533.73 (N=44)
Door	$443.22	$252.31	$4,306.21	$5,001.74	$555.75 (N=9)	$625.22 (N=8)
Fond du Lac	$3,006.86	$1,250.14	$24,028.76	$28,285.76	$1,131.43 (N=25)	$1,229.82 (N=23)
Manitowoc	$980.52	$644.82	$1,722.76	$3,348.10	$111.60 (N=30)	$239.15 (N=14)
Marathon	$1,796.42	$2,506.97	$9,256.77	$13,560.16	$315.35 (N=43)	$376.67 (N=36)
Portage	$326.68	$765.24	$3,872.25	$4,964.17	$310.26 (N=16)	$330.94 (N=15)
Vernon	$279.86	$304.62	$4,981.77	$5,566.25	$506.02 (N=11)	$1,391.56 (N=4)
Waukesha	$2,093.61	$1,739.17	$13,505.61	$17,338.39	$541.82 (N=32)	$559.30 (N=31)
Waupaca	$904.06	$617.01	$8,874.80	$10,395.87	$611.52 (N=17)	$649.74 (N=16)
Totals	$12,410.13	$9,395.39	$90,138.95	$111,944.47	$474.34 (N=236)	$586.10 (N=191)

Statewide, the Projects received some level of TCM for 81% of the clients in the cohort. Four Projects (Door, Portage, Waukesha and Waupaca) were quite diligent about billing for TCM services and received TCM funding for all but one client in their cohort. On average, $586.10 was captured for every case that received some level of TCM reimbursement. Actual TCM reimbursement ranged from $11.40 to $3,184.33 per case. The average funding received per client that had TCM billings ranged from $239.15 in Manitowoc County, which billed for services provided to 47% of their cohort, to $1,391.56 in Vernon County which billed for services provided to 36% of their cohort.

TCM Reimbursements by Client Status. Most of the cases that did not generate TCM funds had been closed prior to the end of the follow-up period. Among the 45 families with no TCM revenues, 36 (80%) had been closed prior to June 30, 2002 and the remaining 9 (20%) were still active. Cases that generated TCM revenues were on average active on POCAN longer than the cases that had no TCM revenues. Among the cases that generated TCM revenues, the time on

[44] Includes cases that had no TCM revenues.

POCAN averaged 588 days and ranged from 22 to 1,080 days. Among the cases that had no TCM revenues, the time on POCAN averaged 356 days and ranged from 45 to 1,031 days.

Use of Flexible Funds

Flexible Funding Requirements. The POCAN enabling legislation (s.s. 46.515 (4)) contains provisions that require Projects to use funding for several types of services that are intended to prevent child abuse and neglect. These include the core program of home visitation services and flexible funds for other services and materials. Flexible funds can be used to help the family meet basic needs or to deal with minor emergencies needed immediately for family safety and functioning. The Projects are allowed to use flexible funds for innovative services that they proposed in their grant application. Total spending on flexible funding is limited to up to $1,000 per case per year. The County must provide a 50% match for all flexible funding expenditures.

Total Flexible Funds Expenditures.

During the four-year time span from program implementation in January 1999 through December 2002, flexible funds expenditures for all POCAN families in the 9 cohort counties totaled $321,478[45] and averaged $425.24 per case per year. Most, but not all POCAN families received some benefits using flexible funds. The proportion of the POCAN total caseload in the 9 cohort counties that used flexible funds each year was CY 1999 - 70%, CY 2000 – 64%, CY 2001 – 60% and CY 2002 – 62%. Data presented on flexible funds expenditures includes services provided to both families from the cohort and also to subsequent POCAN enrollees.

Brown County consistently spent the most money on flexible funds services and also provided services to the greatest number of families. Brown County spent a total of $43,550 during each calendar year and used these funds to provide services to 58 to 60 different families annually. There was extreme variation in the extent to which flexible funds were used in the other POCAN Counties. Total expenditures during CY 1999 through 2002 using flexible funds ranged from $8,016 in Waupaca County to $174,200 in Brown County from 1999 through 2002. Annual per capita expenditures using flexible funds ranged from $49.50 in Vernon County in CY 1999 to $882.35 in Fond du Lac County in 1999. Appendix E provides more detailed information regarding the number of families served and flexible funding total and per capita expenditures by year for each POCAN Project.

[45] This included $160,739 in State funds and $160,739 in County match funds.

Table 21
Total Annual Flexible Funds Expenses CY 1999-2002

POCAN Projects	CY 1999	CY 2000	CY 2001	CY 2002	Total CY 1999-2002
Brown	$43,550	$43,550	$43,550	$43,550	$174,200
Door	$0	$2,892	$3,380	$2,268	$8,540
Fond du Lac	$15,000	$13,040	$6,462	$5,206	$39,708
Manitowoc	$1,224	$7,362	$3,326	$4,114	$16,026
Marathon	$0	$22,232	$5,502	$4,052	$31,786
Portage	$1,632	$6,954	$1,670	$1,744	$12,000
Vernon	$198	$6,106	$3,252	$2,474	$12,030
Waukesha	$0	$2,138	$8,656	$8,378	$19,172
Waupaca	$1,106	$1,500	$3,780	$1,630	$8,016
Total Expenses	$62,710	$105,774	$79,578	$73,416	$321,478
Per Capita Expenses[46]	$674.30	$485.20	$375.37	$315.09	$425.24

Types of Services Provided Using Flexible Funds. A wide variety of services and materials have been provided to POCAN clients using flexible funds. Flexible funds have been used to provide families with basic needs such as food, clothing and shelter. In addition, flexible funds have been used to purchase baby supplies, to facilitate the parent(s)' ability to make positive progress in their life and to resolve short-term crises. All Projects used flexible funds to provide some families with infant car seats. Most Projects also used flexible funds to provide some families with baby furniture, baby layettes, diapers, emergency food, transportation related expenses, health and safety-related home repairs, and housing costs such as security deposits and payment of delinquent utilities. The Projects have indicated that flexible funds have helped alleviate some of the sources of family stress. This allows parents to increase their focus on learning positive parenting behaviors and reducing the likelihood of child abuse and neglect.

Table 18 summarizes the types of services that have been provided to POCAN families with flexible funds. Only the nine Projects in the cohort are included. All services that were provided to families within the cohort as well as to the families enrolled after June 30, 2000 are included in Table 18.

[46] Per capita flexible funds expenses are based on only those families that actually received services using flexible funding. Between 60% and 70% of the POCAN caseload in the 9 cohort counties received goods and/or services paid for with flexible funds each year.

Table 22
Types of Services and Materials Provided to POCAN Clients Using Flexible Funds

Service or Item	Brown County	Door County	Fond du Lac County	Manitowoc County	Marathon County	Portage County	Vernon County	Waukesha County	Waupaca County
Infant Car Seat	X	X	X	X	X	X	X	X	X
Baby Furniture (Cribs, Playpens, High Chair, Stroller, Monitor)	X	X	X	X	X		X		
Basic Baby Layette and Diapers	X	X	X			X	X		X
Emergency Food	X	X	X				X	X	X
Car Related (Repairs, Driver Lessons, Licensing, Gas)	X	X			X	X	X	X	X
Home Repairs (Health/Safety Related)	X	X			X	X	X	X	X
Crisis Rent or Security Deposit	X				X	X	X	X	X
Delinquent Utilities & Crisis Utility Services	X	X	X			X	X	X	X
Health Related (Humidifier, Special Needs Equipment, Emergency Medical/Dental, OTC Meds)				X		X	X		X
Employment Related Supplies (Shoes, Uniforms, Equipment, Watches)	X				X	X	X		
Parenting Education (Child and Family Health and Development)	X		X				X		
Other Educational Services (GED/ACT Test Fees, Budgeting Counseling)		X			X	X			
Urgent Transportation	X	X		X			X		
Household Supplies/Furnishings	X	X		X					
Crisis Child Care	X		X			X			
Expenses Related to POCAN Outreach and Enrollment Activities	X	X	X				X		
Toys and Books	X		X						
Children's Clothing	X								
Moving Expenses	X								
Recreational Activities			X						
AODA Assessment		X							
Supplies for Groups	X								

Use of Wraparound Funds

Wraparound Description and Eligibility Criteria. The wraparound process is intended to provide child abuse/neglect prevention services in a flexible, comprehensive and individualized manner in order to reduce the need for court ordered services. Wraparound cases are distinct from the POCAN home visitation program caseload, and eligibility criteria are also different. Medicaid eligibility is not required to receive services from the wraparound flexible fund, families may have multiple children and the children may be older. Those eligible to receive wraparound services are families who have either been the subject of a child abuse or neglect report or who have asked for assistance to prevent abuse, who are willing to cooperate with an informal plan of services, and for whom there will be no court involvement. Prior to the availability of this funding, the wraparound families were overlooked for assistance until they became substantiated for child abuse/neglect and required more costly intervention or child out-of-home placement. The families receiving wraparound services have a connection to the county child protective services program as they make a determination of potential risk in referred families for child abuse and neglect without assistance. Then, if the family is found at risk, most POCAN counties directly provide them with case management services. Three counties (Brown, Vernon and Manitowoc) assure case management services through a subcontract with private social service or health agencies.

POCAN sites must establish a fund that can be used to provide wraparound services that are directed toward some type of family crisis or event of child abuse risk, but not to a level of substantiated child abuse or neglect. There is a cap of $500 per case for wraparound services. The POCAN Project must match 50% of the money spent on funding for these families. The wraparound funding is to be used to purchase services for which there is no other source of payment and to implement the family's informal plan of care. The family must agree to repay the county for the cost of wraparound services when their financial situation improves.

Wraparound Caseloads and Expenditures. During CY 1999-2002, 593 different families were provided with wraparound services. Expenditures for wraparound services have totaled $235,162[47] from CY 1999-2002. Half of these services were funded using POCAN state GPR grant funds and the county funded half of the cost of services. On average, statewide, $58,790.50 was spent annually on wraparound services. Per case costs for wraparound services have averaged $396.56.

[47] Wraparound costs totaled $54,106 in CY 1999, $72,680 in CY 2000, $62,310 in CY2001 and $46,066 in CY2002. This includes both state and county funding provided to all 10 POCAN counties for wraparound services.

Recommendations. Based on our analysis of outcome data on the POCAN cohort, the study makes several recommendations to improve the POCAN Program. These are:

- **Target the program better to enroll families in close timing to the birth of the child.** Families enrolled at or near the birth of the child have higher program retention rates. This recommendation is consistent with Critical Element #1, which recommends that services should be initiated during the prenatal period or at birth.

- **Assess family functioning and positive parenting practices upon intake and throughout POCAN participation.** Family functioning and parenting practices are currently initially assessed when the child is 6 months old. Most families are enrolled shortly after the birth of the child. Taking baseline measures regarding family functioning and positive parenting practices upon intake will allow the Program to more accurately measure improvements and to better integrate family needs into case planning and service delivery and referrals. Continuously reassessing family functioning and positive parenting practices throughout POCAN participation will allow better integration of case management with service delivery.

- **Thoroughly assess risks using the Prenatal Care Coordination (PNCC) Questionnaire or the Family Questionnaire to better quantify risk level and systematically identify program and treatment needs.** The client risk assessment is done upon intake. Many of the risk dimensions involve the collection of highly sensitive and personal data. In some cases, POCAN staff indicate that they only collect as much data as they need to qualify the family for POCAN services and they informally identify other risks as they build a more knowledgeable and trusting relationship with the family. As a result, the formal risk score may understate the true risk level of the family. It may be appropriate to reevaluate each family's risk following enrollment. This would increase the completeness and validity of POCAN risk scores and allow staff to systematically incorporate risk and need data into each family's case plan.

- **Do more intensive assessment and case management to identify treatment and services needs and additional follow-up to facilitate implementation of referrals.** Linking families with community services and resources is key to the POCAN Program's purpose of preventing child abuse and neglect and promoting the child's health and safety. Extra intervention, including increased follow-up, taking on the role of an active client advocate and expanding collateral contacts may improve the effectiveness of referrals.

  In some areas, the volume and success rate of referrals was quite low. These included alcohol, tobacco and/or other drug abuse programs[48], violence programs and mental health intervention programs. Providing effective treatment and supportive services in these 3 areas is key to preventing child abuse and neglect. Systematic efforts should be made to insure that

[48] For example, substance abuse referrals were considerably lower than one would expect. The DHFS Bureau of Mental Health and Substance Abuse Services estimates that 10% of Wisconsin's adult population has substance abuse treatment needs. Those living below the poverty level and the unemployed have higher rates. The federal government uses a rate of 15 percent among TANF recipients. Only 6% of POCAN families were referred for AODA services.

these sensitive and difficult treatment needs are evaluated and addressed by POCAN staff. DPH may need to develop best practice information and training and tools for POCAN staff in these areas to insure that needs are identified. In those cases where clients do not follow through on referrals, DPH and POCAN staff should identify barriers to service delivery. Potential barriers to service referral and follow-through are varied and could include unavailability of services or waiting lists for services, access barriers such as lack of transportation or child care, client denial of the problem, and/or objections to participating in programming by the client and/or her family/partner. More work may be needed to identify the specific barriers to the implementation of referrals and subsequently take corrective action to resolve these barriers.

Improvements should also be made to increase completion on referrals to services that are particularly critical to the child's health, development and safety, or the family's ability to achieve self-sufficiency. These include parenting programs, the Birth to 3 Program, family planning programs, and employment and educational programs. Participation in parenting programs and parenting support groups is fundamental to the purpose of POCAN. While home visitors provide training and counseling to improve parenting skills, many families needed more support services and intervention than is feasible given POCAN caseloads. Any child that has been diagnosed with a developmental delay or disability should be linked up with the Birth to 3 Program to maximize their early childhood development.

Young, single mothers head most POCAN families and receiving family planning knowledge and services is key to avoiding unwanted subsequent pregnancies and allowing adequate spacing between children. Only 63% of families were referred to family planning programs during the first year of POCAN participation.

Finally, improving the mother's educational and/or employment status provides a strategy to facilitate the family's economic self-sufficiency and also helps to alleviate the stresses of poverty that can contribute to child abuse and neglect. The study found only about half of the employment and/or educational referrals were successful and that relatively few mothers improved their employment and/or educational status while on POCAN.

- **Explore how federal MA funds can be maximized to support the prevention program.** While some Projects captured significant TMC revenues, others made minimal efforts. This is a revenue source that can be used to provide county match for flexible funds services and should not be overlooked, particularly given pending reductions in county budgets that are likely to reduce the availability of these discretionary funds. DPH should work with DHCF staff to provide POCAN staff with additional training on TCM. They should establish an on-going method of providing introductory and advanced training and technical assistance on the TCM billing process and documentation requirements to facilitate effective TCM billings. Such training should include identifying specific POCAN services that are TCM reimbursable and specifying acceptable MA terminology that should be used to report these allowable services in order to secure MA TCM reimbursement.
  The Department should also explore the feasibility of expanding the availability of federal MA funding. For example, it may be possible to use POCAN GPR funds as MA match to

draw increased federal funding for POCAN services. The development of an MA waiver for POCAN is another option that should be explored.

- **Promote service continuity among families that close due to moving.** The families enrolled by POCAN tend to be highly mobile and this interferes with continuity of services. The most common reason for closure[49] from the POCAN Program was that the family moved out of the county. Projects have indicated that frequently these moves are to an adjacent county and that it would have been feasible to continue to serve the family in a similar or less intensive home visitation program. The Department may want to consider a mechanism whereby money can be provided to support services for POCAN families who move elsewhere in Wisconsin to facilitate continuity of services.

- **Analyze options for program expansion to eventually make prevention services available throughout the state.** One of the highest priorities of Governor Doyle's administration is assuring the health and safety of Wisconsin children. The POCAN program effectively delivers services that promote the well-being of at risk children. The Department should evaluate financing options and strategies that will allow the expansion of POCAN services to additional counties. The Department may also want to address a strategy for statewide implementation of POCAN over a reasonable period of time. The POCAN Projects operate in less diverse and small to medium-sized urban counties. Therefore, it will be necessary to further analyze how to achieve best results in implementing POCAN programs in more racially/ethnically diverse and larger counties, taking into account cultural differences and the existing program and service networks in those areas.

[49] 41% of all closures were due to the family moving outside of the enrolling county.

Appendix A
Prevention of Child Abuse and Neglect Program (POCAN)
Division of Public Health's Evaluation of the 12 Critical Quality Elements
Summary of Key Findings and Recommendations

Critical Element 1: Initiate services during the prenatal period or at birth.
Key Finding: Mothers are eligible for the Medicaid Prenatal Care Coordination program and the POCAN home-visiting program, so linkages, including formal processes to ease the transition from one program to another are essential to initiate services during the prenatal period or shortly after the child's birth.

Critical Element 2: Use a standardized assessment to identify families in need of services.
Key Finding: Eligibility tools required by POCAN, though focusing on risks and needs to meet Medicaid requirements, are identifying the appropriate families eligible for the home-visiting program services.

Critical Element 3: Offer services voluntarily and develop a regular visitation schedule with the family.
Key Finding: POCAN home-visiting programs have used a variety of strategies to engage families and enroll them into services. The flexible fund has helped families take care of basic family stresses and build trusting relationships so parents can focus on learning positive parenting practices.

Critical Element 4: Offer services based upon needs, changing the intensity of services over time.
Key Finding: POCAN programs need to establish and use objective criteria that consider the child's age and parental competence and knowledge about child health and development to offer and provide effective home-visiting services.

Critical Element 5: Offer culturally competent services with staff and materials that reflect the populations being served.
Key Finding: Key strategies used by POCAN home-visiting sites that assure culturally competent services included multicultural staff and materials translated in other ethnic languages. Continuous training opportunities for staff is also important to promote a continuing focus on cultural competency of program services.

Critical Element 6: Focus on the parent as well as parent-child interaction and child development.
Key Finding: The POCAN home-visiting programs uniformly focus services that support parent-child interaction and child health and developmental outcomes. Coordination of services is also provided often but is likely the result of being required to implement billing for Medicaid targeted case management.

Critical Element 7: Link all families to a health care provider and other services depending on need.
Key Finding: POCAN home-visiting programs established linkages with a variety of other services in their communities. Commonly POCAN programs established referral relationships with prenatal care coordination programs, teen parenting programs, health care agencies, job services nutrition programs and a variety of social service providers. POCAN home-visiting programs report that the most challenging rural services for families to access are housing, legal help, and transportation assistance.

Critical Element 8: Limit staff caseloads so home visitors can have adequate time with each family.
Key Finding: The POCAN home-visiting programs limit caseloads to assure appropriate and adequate services to enrolled families. POCAN funds are crucial for programs to enable them to maintain quality

programs for families in their communities. However, limiting caseloads without increasing allocations has resulted in the need to establish waiting lists for program services.

Critical Element 9: Select appropriately prepared staff who are skilled and willing to work with diverse communities.
Key Finding: POCAN home-visiting programs reported generally that the types of staff that work in the home-visiting POCAN programs reflect a partnership of professionals and trained paraprofessionals. A total of 13.5 full time equivalent Family Support Home Visitors were employed by all ten POCAN sites. Several POCAN home-visiting programs employed registered nurses or social workers to work with the home visitor and to provide Medicaid targeted case management services.

Critical Element 10: Select staff whose education and/or experiences enable them to handle the experiences of working with overburdened families.
Key Finding: The ability of the POCAN home-visiting program supervisors to provide adequate support to their diverse home visitors, who work with challenged families, is integral to promoting individual, family, and child achievements.

Critical Element 11: Provide staff with intensive training specific to family assessment and home visitation.
Key Finding: From 1999-2002, 98 POCAN-specific training events were held through a contract with University of Wisconsin-Extension with approximately 2,200 participants. These trainings addressed specific topics and ongoing training and technical assistance needs. Many POCAN programs reported improvements in knowledge and skill of their staff because of the training. POCAN sites also report networking and learning what other programs do to be very helpful in improving the overall quality of their program services.

Critical Element 12: Ensure that staff receive ongoing supervision so they can develop realistic and effective plans to help families meet their objectives, aid those who may not be making progress, and discuss their concerns to solve problems and avoid stress-related burnout.
Key Finding: All POCAN programs report that supervision and planning meetings for their home visitors are held regularly, often biweekly. The supervisors are on call to the home visitors as needed between scheduled meetings.

RECOMMENDATIONS:

- Increase the base award to each program from $10,000 to $20,000 per qualifying program to adequately fund staff and services to at-risk families in smaller counties or tribes.

- Continue home-visiting services for families who lose Medicaid eligibility but continue to score as high risk until the child becomes three.

- Continue support of the training and technical assistance contract with any program expansion of POCAN as it is an integral support for home-visiting staff of the projects to assure quality programs and services for high-risk families.

A complete copy of the Division of Public Health's Evaluation of the 12 Critical Quality Elements may be obtained from the Division of Public Health.

Appendix B

1997 Wisconsin Act 293

Date of enactment: **June 16, 1998**

1997 Senate Bill 378 Date of publication*: **June 30, 1998**

1997 WISCONSIN ACT 293

AN ACT ***to amend*** 48.981 (8) (a), 48.981 (8) (d) 1., 48.982 (4) (a), 48.982 (6) (a), 48.982 (6) (d) and 49.45 (25) (c); ***to repeal and recreate*** 25.67 (2) (a) 1. and (b); and ***to create*** 20.435 (3) (de), 20.435 (3) (df) and 46.515 of the statutes; **relating to:** creating a child abuse and neglect prevention program, medical assistance for certain case management services, child abuse and neglect prevention and early childhood family education center grants awarded by the child abuse and neglect prevention board, training programs and training requirements for staff of county departments or licensed child welfare agencies under contract with county departments whose responsibilities include investigation or treatment of child abuse and neglect and making appropriations.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

				1997–98	1998–99
20.435	**Health and family services, department of**				
(3)	CHILDREN AND FAMILY SERVICES				
(de)	Child abuse and neglect prevention grants	GPR	A	–0–	995,700
(df)	Child abuse and neglect prevention technical assistance	GPR	A	–0–	160,000

SECTION 3. 20.435 (3) (de) of the statutes is created to read:

20.435 **(3)** (de) *Child abuse and neglect prevention grants*. The amounts in the schedule for child abuse and neglect prevention grants under s. 46.515.

SECTION 4. 20.435 (3) (df) of the statutes is created to read:

20.435 **(3)** (df) *Child abuse and neglect prevention technical assistance.* The amounts in the schedule for child abuse and neglect prevention technical assistance and training under s. 46.515 (8).

SECTION 6. 25.67 (2) (a) 1. and (b) of the statutes, as affected by 1997 Wisconsin Acts 27 and 78, are repealed and recreated to read:

* Section 991.11, WISCONSIN STATUTES 1995–96: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

25.67 **(2)** (a) 1. Moneys received for the fund under s. 48.982 (2) (d) or (2e) (a).

(b) All moneys in the fund that are not appropriated under s. 20.433 (1) (r) or expended under s. 20.433 (1) (q) shall continue to accumulate indefinitely.

SECTION 7. 46.515 of the statutes is created to read:

46.515 Child abuse and neglect prevention program. (1) DEFINITIONS. In this section:

(a) "Abuse" has the meaning given in s. 48.02 (1).

(b) "Case", other than when used in the term "case management services", means a family or person who meets all of the following criteria:

1. The family or person is any of the following:

a. A family or person who has been the subject of a report under s. 48.981 and with respect to whom the individual making the investigation or the intake worker assigned to the family or person has determined that all of the conditions in subd. 2. exist.

b. An Indian child who has been the subject of a report under s. 48.981 about which an Indian tribe that has received a grant under this section has received notice, including but not limited to notice provided to a tribal agent under s. 48.981 (3) (bm), and with respect to whom an individual designated by the Indian tribe has determined that all of the conditions in subd. 2. exist.

c. A family that includes a person who has contacted a county department, as defined in s. 48.02 (2g), or an Indian tribe that has been awarded a grant under this section or, in a county having a population of 500,000 or more that has been awarded a grant under this section, the department or a licensed child welfare agency under contract with the department requesting assistance to prevent abuse or neglect of a child in the person's family and with respect to which an individual responding to the request has determined that all of the conditions in subd. 2. exist.

2. The family or person has been determined to meet all of the following conditions:

a. There is a substantial risk of future abuse or neglect of a child in the family if assistance is not provided.

b. The child and the child's parent or the person primarily responsible for the child's care are willing to cooperate with an informal plan of support and services.

c. It does not appear that a petition will be filed under s. 48.25 alleging that a child in the family is in need of protection or services under s. 48.13 and, if an Indian child is involved, it also does not appear that there will be a similar proceeding in tribal court relating to abuse or neglect of the Indian child.

(c) "Court", other than when used in referring to a tribal court, has the meaning given in s. 48.02 (2m).

(cm) "Culturally competent" means the ability to understand and act respectfully toward, in a cultural context, the beliefs, interpersonal styles, attitudes and behaviors of persons and families of various cultures.

(d) "Indian child" has the meaning given in s. 48.981 (1) (cs).

(e) "Indian tribe" means a federally recognized American Indian tribe or band in this state.

(f) "Intake worker" means any person designated to provide intake services under s. 48.067.

(g) "Neglect" has the meaning given in s. 48.981 (1) (d).

(h) "Reservation" means land in this state within the boundaries of a federally recognized reservation of an Indian tribe or within the bureau of Indian affairs service area for the Ho–Chunk Nation.

(i) "Rural county" means a county that is not an urban county.

(j) "Urban county" means a county located in a federal metropolitan statistical area or a primary metropolitan statistical area, as designated by the federal office of management and budget.

(2) FUNDS PROVIDED. If a county or Indian tribe applies and is selected by the department under sub. (5) to participate in the program under this section, the department shall award, from the appropriation under s. 20.435 (3) (de), a grant annually to be used only for the purposes specified in sub. (4) (a) and (am). The minimum amount of a grant is $10,000. The department shall determine the amount of a grant awarded to a county, other than a county with a population of 500,000 or more, or Indian tribe in excess of the minimum amount based on the number of births that are funded by medical assistance under subch. IV of ch. 49 in that county or the reservation of that Indian tribe in proportion to the number of births that are funded by medical assistance under subch. IV of ch. 49 in all of the counties and the reservations of all of the Indian tribes to which grants are awarded under this section. The department shall determine the amount of a grant awarded to a county with a population of 500,000 or more in excess of the minimum amount based on 60% of the number of births that are funded by medical assistance under subch. IV of ch. 49 in that county in proportion to the number of births that are funded by medical assistance under subch. IV of ch. 49 in all of the counties and the reservations of all of the Indian tribes to which grants are awarded under this section.

(3) NUMBER OF COUNTIES AND INDIAN TRIBES SELECTED. (a) *Number selected.* In the 1997–99 state fiscal biennium, no more than 6 rural counties, 3 urban counties and 2 Indian tribes may be selected by the department to participate in the program under this section.

(b) *Joint application permitted.* Two or more counties and Indian tribes may submit a joint application to the department. Each county or Indian tribe in a joint application shall be counted as a separate county or Indian tribe for the purpose of limiting the number of counties and Indian tribes selected in each state fiscal biennium.

(4) PURPOSE. (a) *Grants; flexible funds, training and case management.* The grants awarded under this section shall be used for all of the following purposes:

1. To establish or maintain the fund under sub. (6) (b) 1.

2. To establish or maintain the fund under sub. (6) (b) 2.

4. To pay expenses incurred in connection with attending training activities related to the program under this section. No more than $1,500 of the grant amount may be used for this purpose in the 12 months following receipt of a grant.

4m. Other than in a county with a population of 500,000 or more, to reimburse a case management provider under s. 49.45 (25) (b) for the amount of the allowable charges under the medical assistance program that is not provided by the federal government for case management services provided to a medical assistance beneficiary described in s. 49.45 (25) (am) 9. who is a child and who is a member of a family that receives home visitation program services under par. (b) 1.

(am) *Grants; start–up costs and capacity building.* In the first year in which a grant under this section is awarded to a county or Indian tribe, the county or Indian tribe may use a portion of the grant to pay for start–up costs and capacity building related to the program under this section. The department shall determine the maximum amount of a grant that a county or Indian tribe may use to pay for those start–up costs and that capacity building.

(b) *Home visitation program services.* 1. A county, other than a county with a population of 500,000 or more, or an Indian tribe that is selected to participate in the program under this section shall select persons who are first–time parents and who are eligible for medical assistance under subch. IV of ch. 49 and shall offer each of those persons an opportunity to undergo an assessment through use of a risk assessment instrument to determine whether the parent presents risk factors for perpetrating child abuse or neglect. Persons who are selected and who agree to be assessed shall be assessed during the prenatal period, if possible, or as close to the time of the child's birth as possible. The risk assessment instrument shall be developed by the department and shall be based on risk assessment instruments developed by the department for similar programs that are in operation. The department need not promulgate as rules under ch. 227 the risk assessment instrument developed under this subdivision. A person who is assessed to be at risk of abusing or neglecting his or her child shall be offered home visitation program services. Home visitation program services may be provided to a family with a child identified as being at risk of child abuse or neglect until the identified child reaches 3 years of age. If risk factors for child abuse or neglect with respect to the identified child continue to be present when the child reaches 3 years of age, home visitation program services may be provided until the identified child reaches 5 years of age. Home visitation program services may not be provided to a person unless the person gives his or her written informed consent to receiving those services or, if the person is a child, unless the child's parent, guardian or legal custodian gives his or her written informed consent for the child to receive those services.

1m. No person who is required or permitted to report suspected or threatened abuse or neglect under s. 48.981 (2) may make or threaten to make such a report based on a refusal of a person to receive or to continue receiving home visitation program services under subd. 1.

2. The counties and Indian tribes that are selected to participate in the program under this section may permit a person who is not a first–time parent or who is not eligible for medical assistance under subch. IV of ch. 49 to undergo the risk assessment and to participate in the home visitation program if that person presents risk factors for perpetrating child abuse or neglect. No payments from the fund under sub. (6) (b) 1. may be made to a person described in this subdivision. No reimbursement to a case management provider under s. 49.45 (25) (b) for services provided to a person described in this subdivision may be made from grant moneys received under this section.

(5) SELECTION OF COUNTIES AND INDIAN TRIBES. The department shall provide competitive application procedures for selecting counties and Indian tribes for participation in the program under this section. The department shall establish a method for ranking applicants for selection based on the quality of their applications. In ranking the applications submitted by counties, the department shall give favorable consideration to a county that has indicated under sub. (6) (d) 2. that it is willing to use a portion of any moneys distributed to the county under s. 46.45 (2) (a) to provide case management services to a medical assistance beneficiary under s. 49.45 (25) (am) 9. who is a case or who is a member of a family that is a case and that has explained under sub. (6) (d) 2. how the county plans to use that portion of those moneys to promote the provision of those services for the case by using a wraparound process so as to provide those services in a flexible, comprehensive and individualized manner in order to reduce the necessity for court–ordered services. The department shall also provide application requirements and procedures for the renewal of a grant awarded under this section. The application procedures and the renewal application requirements and procedures shall be clear and understandable to the applicants. The department need not promulgate as rules under ch. 227 the application procedures, the renewal application requirements or procedures or the method for ranking applicants established under this subsection.

(6) CRITERIA FOR AWARDING GRANTS. In addition to any other criteria developed by the department, a county or Indian tribe shall meet all of the following criteria in order to be selected for participation in the program under this section:

(a) *Home visitation program criteria.* The part of an application, other than a renewal application, submitted by a county, other than a county with a population of 500,000 or more, or an Indian tribe that relates to home visitation programs shall include all of the following:

1. Information on how the applicant's home visitation program is comprehensive and incorporates practice standards that have been developed for home visitation programs by entities concerned with the prevention of child abuse and neglect and that are acceptable to the department.

2. Documentation that the application was developed through collaboration among public and private organizations that provide services to children, especially children who are at risk of child abuse or neglect, or that are otherwise interested in child welfare and a description of how that collaboration effort will support a comprehensive home visitation program.

3. An identification of existing child abuse and neglect prevention services that are available to residents of the county or reservation of the Indian tribe and a description of how those services and any additional needed services will support a comprehensive home visitation program.

4. An explanation of how the home visitation program will build on existing child abuse and neglect prevention programs, including programs that provide support to families, and how the home visitation program will coordinate with those programs.

4m. An explanation of how the applicant will encourage private organizations to provide services under the applicant's home visitation program.

6. An identification of how the home visitation program is comprehensive and incorporates the practice standards for home visitation programs referred to in subd. 1., including how services will vary in intensity levels depending on the needs and strengths of the participating family.

6m. An explanation of how the services to be provided under the home visitation program, including the risk assessment under sub. (4) (b) 1., will be provided in a culturally competent manner.

7m. A statement of whether the applicant intends to use a portion of the grant in the first year in which the grant is awarded to pay for start–up costs or capacity building related to the program under this section and an explanation of how the applicant would use any amounts authorized by the department under sub. (4) (am) for those purposes.

(b) *Flexible funds.* 1. 'Flexible fund for home visitation programs.' The applicant demonstrates in the application that the applicant has established, or has plans to establish, if selected, a fund from which payments totaling not more than $1,000 per calendar year may be made for appropriate expenses of each family that is participating in the home visitation program under sub. (4) (b) 1. or that is receiving home visitation services under s. 49.45 (44). The payments shall be authorized by an individual designated by the applicant. If an applicant makes a payment to or on behalf of a family under this subdivision, one–half of the payment shall be from grant moneys received under this section and one–half of the payment shall be from moneys provided by the applicant from sources other than grant moneys received under this section.

2. 'Flexible fund for cases.' The applicant demonstrates in the grant application that the applicant has established, or has plans to establish, if selected, a fund from which payments totaling not more than $500 for each case may be made for appropriate expenses related to the case. The payments shall be authorized by an individual designated by the applicant. If an applicant makes a payment to or on behalf of a person under this subdivision, one–half of the payment shall be from grant moneys received under this section and one–half of the payment shall be from moneys provided by the applicant from sources other than grant moneys received under this section. The applicant shall demonstrate in the grant application that it has established, or has plans to establish, if selected, procedures to encourage, when appropriate, a person to whom or on whose behalf payments are made under this subdivision to make a contribution to the fund described in this subdivision up to the amount of payments made to or on behalf of the person when the person's financial situation permits such a contribution.

4. 'Nonentitlement.' No individual is entitled to any payment from a fund established under subd. 1. or 2. Nothing in this section shall be construed as requiring a county or Indian tribe to make a determination described in sub. (1) (b) 2. A determination described in sub. (1) (b) 2. may not be construed to be a determination described in s. 48.981 (3) (c) 4.

(c) *Case management benefit.* The applicant, other than a county with a population of 500,000 or more, states in the grant application that it has elected, or, if selected, that it will elect, under s. 49.45 (25) (b), to make the case management benefit under s. 49.45 (25) available to the category of beneficiaries under s. 49.45 (25) (am) 9. who are children and who are members of families receiving home visitation program services under sub. (4) (b) 1.

(d) *Wraparound process.* 1. The applicant demonstrates in the grant application that the payments that will be made from the fund established under par. (b) 2. will promote the provision of services for the case by using a wraparound process so as to provide those services in a flexible, comprehensive and individualized manner in order to reduce the necessity for court–ordered services.

2. The applicant indicates in the grant application whether the applicant is willing to use a portion of any moneys distributed to the applicant under s. 46.45 (2) (a) to provide case management services to a medical assistance beneficiary under s. 49.45 (25) (am) 9. who is a case

or who is a member of a family that is a case. If the applicant is so willing, the applicant shall explain how the applicant plans to use that portion of those moneys to promote the provision of those services for the case by using a wraparound process so as to provide those services in a flexible, comprehensive and individualized manner in order to reduce the necessity for court–ordered services.

(e) *Anticipated allocation.* The applicant explains in the grant application how the applicant anticipates allocating moneys awarded under the grant among the purposes described in sub. (4) (a) 1., 2. and 4m. and, in an application other than a renewal application, the purposes described in sub. (4) (a) 1., 2. and 4m. and (am).

(6g) CONFIDENTIALITY. (a) Except as permitted or required under s. 48.981 (2), no person may use or disclose any information concerning any individual who is selected for an assessment under sub. (4) (b), including an individual who declines to undergo the assessment, or concerning any individual who is offered services under a home visitation program funded under this section, including an individual who declines to receive those services, unless the use or disclosure is connected with the administration of the home visitation program or the administration of the medical assistance program under ss. 49.43 to 49.497 or unless the individual has given his or her written informed consent to the use or disclosure.

(b) A county or Indian tribe that is selected to participate in the program under this section shall provide or shall designate an individual or entity to provide an explanation of the confidentiality requirements under par. (a) to each individual who is offered an assessment under sub. (4) (b) or who is offered services under the home visitation program of the county or Indian tribe.

(6m) NOTIFICATION OF PARENT PRIOR TO MAKING ABUSE OR NEGLECT REPORT. If a person who is providing services under a home visitation program under sub. (4) (b) 1. determines that he or she is required or permitted to make a report under s. 48.981 (2) about a child in a family to which the person is providing those services, the person shall, prior to making the report under s. 48.981 (2), make a reasonable effort to notify the child's parent that a report under s. 48.981 (2) will be made and to encourage the parent to contact a county department under s. 46.22 or 46.23 to request assistance. The notification requirements under this subsection do not affect the reporting requirements under s. 48.981 (2).

(6r) HOME VISITATION PROGRAM INFORMATIONAL MATERIALS. Any informational materials about a home visitation program under sub. (4) (b) 1. that are distributed to a person who is offered or who is receiving home visitation program services under that program shall state the sources of funding for the program.

(7) HOME VISITATION PROGRAM EVALUATION. (a) The department shall conduct or shall select an evaluator to conduct an evaluation of the home visitation program. The evaluation shall measure all of the following criteria in families that have participated in the home visitation program and that are selected for evaluation:

1. The number of substantiated reports of child abuse and neglect.

2. The number of emergency room visits for injuries to children.

3. The number of out–of–home placements of children.

4. Immunization rates of children.

5. The number of services provided under s. 49.46 (2) (a) 2. to children.

6. Any other items that the department determines to be appropriate for evaluation.

(b) In the evaluation, the department shall determine the number of families who remained in the home visitation program for the time recommended in the family's case plan.

(c) The department shall determine the most appropriate way to evaluate the following criteria and shall evaluate those criteria as part of the evaluation:

1. Strengthened family functioning.

2. Enhanced child development.

3. Positive parenting practices.

(8) TECHNICAL ASSISTANCE AND TRAINING. The department shall provide technical assistance and training to counties and Indian tribes that are selected to participate in the program under this section.

SECTION 8. 48.981 (8) (a) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

48.981 **(8)** (a) The department, the county departments and a licensed child welfare agency under contract with the department in a county having a population of 500,000 or more to the extent feasible shall conduct continuing education and training programs for staff of the department, the county departments, a licensed child welfare agency under contract with the department or a county department, and the tribal social services departments, persons and officials required to report, the general public and others as appropriate. The programs shall be designed to encourage reporting of child abuse and neglect, to encourage self–reporting and voluntary acceptance of services and to improve communication, cooperation and coordination in the identification, prevention and treatment of child abuse and neglect. Programs provided for staff of the department, county departments and licensed child welfare agencies under contract with county departments or, in a county having a population of 500,000 or more, the department whose responsibilities include the investigation or treatment of child abuse or neglect shall also be designed to provide information on means of recognizing and appropriately responding to domestic abuse, as defined in s. 46.95 (1) (a). The department, the county departments and a licensed child welfare agency under contract with the department in a county having a population of 500,000 or more shall de-

velop public information programs about child abuse and neglect.

SECTION 9. 48.981 (8) (d) 1. of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

48.981 **(8)** (d) 1. Each agency staff member and supervisor whose responsibilities include investigation or treatment of child abuse and neglect shall successfully complete training in child abuse and neglect protective services approved by the department. The training shall include information on means of recognizing and appropriately responding to domestic abuse, as defined in s. 46.95 (1) (a). The department shall monitor compliance with this subdivision according to rules promulgated by the department.

SECTION 11. 48.982 (4) (a) of the statutes is amended to read:

48.982 **(4)** (a) From the appropriations under s. 20.433 (1) (h), (i), (k), (m) and (q), the board shall award grants to organizations in accordance with the plan developed under sub. (2) (a). In each of the first 2 fiscal years in which grants are awarded, no organization may receive a grant or grants totaling more than ~~$15,000~~ $30,000.

SECTION 12. 48.982 (6) (a) of the statutes is amended to read:

48.982 **(6)** (a) From the appropriations under s. 20.433 (1) (b), (h), (i), (k), (ma) and (q), the board shall award grants to organizations in accordance with the request–for–proposal procedures developed under sub. (2) (a). No organization may receive a grant or grants under this subsection totaling more than ~~$75,000~~ $150,000 in any year.

SECTION 13. 48.982 (6) (d) of the statutes is amended to read:

48.982 **(6)** (d) The board shall award grants to organizations for programs that provide parenting education services but not crisis intervention. Grants shall be used for direct parent education and referrals to other social services programs and outreach programs, including programs that provide education to parents in their homes. For organizations applying for grants for the first time on or after the effective date of this paragraph .... [revisor inserts date], the board shall give favorable consideration in awarding grants to organizations for programs in communities where home visitation programs that provide in–home visitation services to parents with newborn infants are in existence or are in development and, if grants are awarded, shall require programs supported by grants to maximize coordination with these home visitation programs. Programs supported by the grants shall track individual clients to ensure that they receive necessary services and shall emphasize direct services to families with children who are 3 years of age or less.

SECTION 14. 49.45 (25) (c) of the statutes is amended to read:

49.45 **(25)** (c) Except as provided in pars. (b), (be) and (bg), the department shall reimburse a provider of case management services under this subsection only for the amount of the allowable charges for those services under the medical assistance program that is provided by the federal government.

SECTION 16. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The repeal and recreation of section 25.67 (2) (a) 1. and (b) of the statutes takes effect on January 1, 1999.

Appendix C
POCAN Budgeted GPR Funding During Calendar Year 1999 to 2003

POCAN Projects	Annual POCAN GPR Allocations					Totals
	CY 1999*	CY 2000	CY 2001	CY 2002	CY 2003	
Brown County	$397,690	$265,130	$265,130	$265,130	$265,130	$1,458,210
Door County	$53,573	$35,715	$35,715	$35,715	$35,715	$196,433
Fond du Lac County	$167,991	$111,994	$111,994	$111,994	$111,994	$615,967
Manitowoc County	$122,051	$81,367	$81,367	$81,367	$81,367	$447,519
Marathon County	$236,903	$157,935	$157,935	$157,935	$157,935	$868,643
Portage County	$117,284	$78,189	$78,189	$78,189	$78,189	$430,040
Vernon County	$55,740	$37,160	$37,160	$37,160	$37,160	$204,380
Waukesha County	$210,032	$140,021	$140,021	$140,021	$140,021	$770,116
Waupaca County	$93,879	$62,586	$62,586	$62,586	$62,586	$344,223
Lac Courte Oreilles Tribe	$38,405	$25,603	$25,603	$25,603	$25,603	$140,817
Statewide	$1,493,548	$995,700	$995,700	$995,700	$995,700	$5,476,348

*Includes one-time startup, capacity building and operations funding

Appendix D

Home Assessment Instrument

Infant/Toddler HOME

Place a plus (+) or minus (-) in the box alongside each item if the behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment. Enter the subtotal and the total on the front side of the Record Sheet.

I. RESPONSIVITY		24. Child has a special place for toys and treasures.	
1. Parent spontaneously vocalizes to child at least at least twice.		25. Child's play environment is safe.	
2. Parent responds verbally to child's vocalizations or verbalizations.		**IV. LEARNING MATERIALS**	
3. Parent tells child name of object or person during visit.		26. Muscle activity toys or equipment.	
4. Parent's speech is distinct, clear and audible.		27. Push or pull toy.	
5. Parent initiates verbal interchanges with Visitor.		28. Stroller or walker, kiddie car, scooter, or tricycle.	
6. Parent converses freely and easily.		29. Parent provides toys for child to play with during visit.	
7. Parent permits child to engage in "messy" play.		30. Cuddly toy or role-playing toys.	
8. Parent spontaneously praises child at least twice.		31. Learning facilitators-mobile, table and chair, high chair, play pen.	
9. Parent's voice conveys positive feelings toward child.		32. Simple eye-hand coordination toys.	
10. Parent caresses or kisses child at least once.		33. Complex eye-hand coordination toys.	
11. Parent responds positively to praise of child offered by Visitor.		34. Toys for literature and music.	
II. ACCEPTANCE		**V. INVOLVEMENT**	
12. Parent does not shout at child.		35. Parent keeps child in visual range, looks at often.	
13. Parent does not express overt annoyance with, or hostility to child.		36. Parent talks to child while doing household work.	
14. Parent neither slaps nor spanks child during visit.		37. Parent consciously encourages developmental advance.	
15. No more than 1 instance of physical punishment during past week.		38. Parent invests maturing toys with value via personal attention.	
16. Parent does not scold or criticize child during visit.		39. Parent structures child's play periods.	
17. Parent does not interfere with or restrict child 3 times during visit.		40. Parent provides toys that challenge child to develop new skills.	
18. At least 10 books are present and visible.		**VI. VARIETY**	
19. Family has a pet.		41. Father provides some care daily.	
III. ORGANIZATION		42. Parent reads stories to child at least 3 times weekly.	
20. Child care, if used, is provided by one of three regular substitutes.		43. Child eats at least one meal a day with mother and father.	
21. Child is taken to grocery store at least once a week.		44. Family visits relatives or receives visits once a month or so.	
22. Child gets out of house at least 4 times a week.		45. Child has 3 or more books of his/her own.	
23. Child is taken regularly to doctor's office or clinic:			
TOTALS: I _____ II _____ III _____ IV _____ V _____ VI _____ TOTAL _____			

Appendix E
Flexible Funds Expenditures During CY 1999-2002 by POCAN Projects in the Study Cohort

	CY 1999			CY 2000			CY 2001			CY 2002		
POCAN Project	Total Costs	# Families Served	Per Capita Costs	Total Costs	# Families Served	Per Capita Costs	Total Costs	# Families Served	Per Capita Costs	Total Costs	# Families Served	Per Capita Costs
Brown	$43,550	60	$725.83	$43,550	60	$725.83	$43,550	58	$750.86	$43,550	60	$725.83
Door	$0	0		$2,892	18	$160.67	$3,380	21	$160.95	$2,268	21	$108.00
Fond du Lac	$15,000	17	$882.35	$13,040	30	$434.67	$6,462	29	$222.83	$5,206	25	$208.24
Manitowoc	$1,224	5	$244.80	$7,362	22	$334.64	$3,326	26	$127.92	$4,114	19	$216.53
Marathon	$0	0		$22,232	51	$435.92	$5,502	25	$220.08	$4,052	18	$225.11
Portage	$1,632	2	$816.00	$6,954	10	$695.40	$1,670	7	$238.57	$1,744	4	$436.00
Vernon	$198	4	$49.50	$6,106	13	$469.69	$3,252	16	$203.25	$2,474	10	$247.40
Waukesha	$0	0		$2,138	6	$356.33	$8,656	22	$393.45	$8,378	28	$299.21
Waupaca	$1,106	5	$221.20	$1,500	8	$187.50	$3,780	8	$472.50	$1,630	48	$33.96
Totals	$62,710	93	$674.30	$105,774	218	$485.20	$79,578	212	$375.37	$73,416	233	$315.09